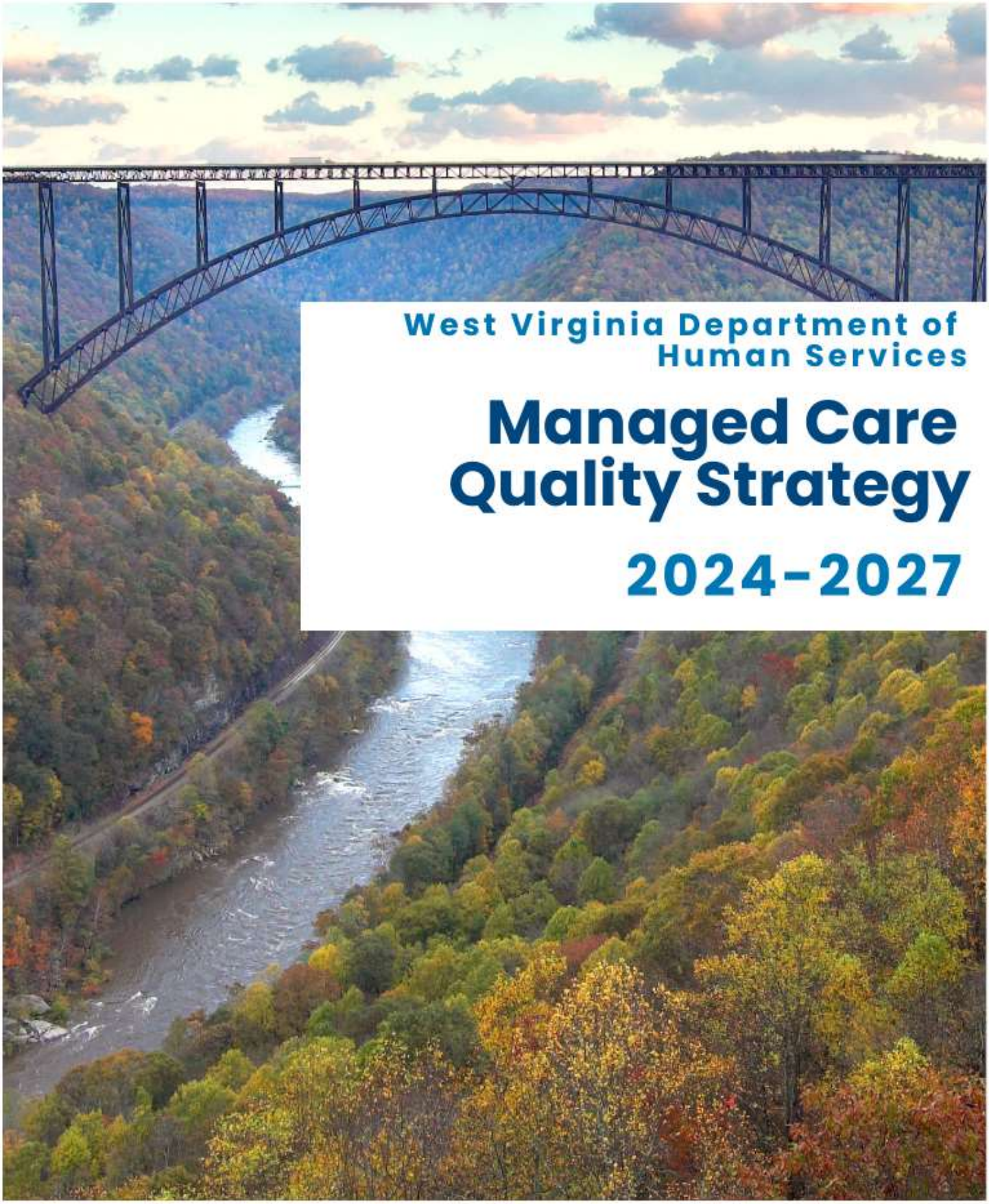

West Virginia Department of Human Services

Managed Care Quality Strategy

2024-2027

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Draft Version 4

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Section 1: Introduction and Overview

The 2024-2027 West Virginia Managed Care Quality Strategy (Managed Care Quality Strategy) is a framework to guide the West Virginia Department of Human Services (DoHS), Bureau for Medical Services (BMS) in providing quality health care services for all West Virginia Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) members. BMS is the single State agency responsible for administering Medicaid and WVCHIP programs. The BMS Office of Quality Management (OQM) is responsible for monitoring and overseeing continuous improvement of the State's two Medicaid managed care programs, Mountain Health Trust (MHT) and Mountain Health Promise (MHP).

The purpose of the BMS Managed Care Quality Strategy is to:

- Serve as a tool and resource that articulates the DoHS and BMS vision for delivery of health care services.
- Provide a proactive data-driven strategy for the BMS to improve health outcomes for Medicaid and WVCHIP members by strengthening quality and performance improvement.
- Provide a framework for assessing and improving the quality of health care and services furnished by managed care organizations (MCOs) in accordance with 42 Code of Federal Regulation (CFR) §438.340. Required CFR elements are listed in Appendix A.
- Align with the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy.
- Serve as a roadmap for operationalizing a dynamic approach to assessing, monitoring, and improving the quality of health care provided under managed care.

As illustrated in *Figure 1*, the BMS mission centers on a commitment to administering the Medicaid program that emphasizes maintaining accountability for the use of resources, in a manner that ensures access to appropriate, medically necessary, and quality health care services for all members. The BMS provides services in a user-friendly manner to providers and members alike and focuses on the future by providing preventative care programs.[1]

Figure 1: West Virginia BMS Mission

The Managed Care Quality Strategy aims to further the mission by defining the goals and objectives of West Virginia's Medicaid and WVCHIP programs to drive improvements in care

[1] West Virginia Bureau for Medical Services (n..d) Mission Statement.

delivery, and the outcomes and metrics by which progress will be measured. It sets a clear direction for priority interventions and details the standards and mechanisms for the BMS to work with the MCOs to achieve desired outcomes. Combined with the proper prioritization of performance improvement projects (PIPs) and value-based programs, The MCOs will work to improve care provided to members and thereby improve overall health outcomes in West Virginia. The 2024-2027 Managed Care Quality Strategy goals are detailed in *Figure 2* and further described in Section 3.

Figure 2: West Virginia Managed Care Quality Strategy Goals

The BMS has developed a Managed Care Quality Strategy that focuses extensively on the following:

- Ensuring alignment of Managed Care Quality Strategy goals, objectives, and measures with BMS initiatives driving health care quality, including a performance or quality withhold program for the MHT program and value-based payment initiatives.
- Developing methods for MCOs to influence outcomes-based measures and benchmark to national performance measures.
- Establishing a foundation to continually evolve health disparities and equity initiatives in future iterations.

Within each of the five goals identified in *Figure 2*, the BMS has defined specific objectives linked to individual performance measures. Objectives set a target for improvement that reflects national benchmarks (e.g., National Committee for Quality Assurance [NCQA] Healthcare Effectiveness Data and Information Set [HEDIS®] Medicaid national average).[2] While the desired outcome at the end of state fiscal year (SFY) 2027 is to meet or exceed measure thresholds, the BMS has outlined interim targets for incremental progress over the course of the three years of this Managed Care Quality Strategy. This approach allows the OQM to actively coordinate and drive quality improvement and monitor progress systematically. The BMS may update the list of selected quality measures as measures are added, or retired by NCQA, and amend benchmarks as targets are achieved, as appropriate. Details related to performance targets can be found in Appendix B, which provides a tracking tool to measure data-driven progress toward achievement of Managed

[2] HEDIS is a comprehensive set of standardized performance measures designed to provide consumers with information they need to compare health plan performance.

Care Quality Strategy goals. Detailed planning regarding monitoring quality improvement is outlined further in an implementation and maintenance plan in Appendix C.

1.1 West Virginia Medicaid and WVCHIP Program Overview

Since 1996, the BMS Center for Managed Care has operated a risk-based Medicaid managed care program that has grown into the predominant service delivery model through MHT and MHP. The BMS contracts with MCOs for the provision of medically necessary services for members, including acute and preventive health care services, as well as valuable supports to help members manage their health care (e.g., care coordination). Additionally, the MCOs provide a wide range of supplementary services, including coordination with social services such as housing and nutrition, non-emergency medical transportation (NEMT), and health education.

In SFY 2023, more than 78 percent of Medicaid members were enrolled in the MHT and MHP programs, while 22 percent received services through the fee-for-service (FFS) delivery system. The majority of FFS members are receiving long-term services and supports (LTSS) through enrollment in home-and community-based (HCBS) waiver programs. With the exception of qualifying children with serious emotional disorders, individuals who are eligible for MHP can opt out of managed care to be served under FFS. Additionally, individuals may be served through the FFS delivery system for a brief period prior to enrollment with an MCO. Following is an overview of the MHT and MHP programs, which are included in the scope of the Managed Care Quality Strategy.

1.1.1 Mountain Health Trust Program

The MHT program provides essential healthcare coverage to children and adults with low income and eligible individuals with disabilities. West Virginia expanded coverage to low-income adults under the Affordable Care Act Medicaid expansion option and integrated these members into the MHT delivery system. These populations are enrolled in the MHT program under Section 1915(b) waiver authority of the Social Security Act of 1981, Sec. 1915. [42 U.S.C. 1396n]. As of February 2024, MHT serves approximately 410,792 members.[3]

West Virginia has Title XXI State Plan authority for the WVCHIP. The WVCHIP members received benefits through the Public Employees Insurance Agency (PEIA) until July 1, 2021, when the BMS shifted service delivery for these members into managed care. As of July 1, 2023 (SFY2024), the BMS consolidated the MHT MCO contracts to include both Medicaid and WVCHIP. The WVCHIP adopted the Medicaid benefits package for medical, behavioral, and dental health services. On July 1, 2024, the WVCHIP intends to adopt the Medicaid pharmacy benefit. Over 24,400 children under the age of 19 and pregnant women are enrolled in WVCHIP.[4]

Currently, the MHT market share consists of three MCOs: Aetna Better Health of West Virginia (36 percent), The Health Plan of West Virginia (25 percent), and UniCare Health Plan of West Virginia (39 percent). As of July 1, 2024, the BMS will transition from three to four contracted MCOs, with the addition of Highmark Health of West Virginia, for the provision of services to MHT members.

[3] Monthly Managed Care Enrollment Report, 2024. https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/Managed%20Care%20Monthly%20Enrollment%20Report%20February%202024.pdf

[4] Ibid

1.1.2 Mountain Health Promise Managed Care Program

MHP is a specialized managed care program that BMS implemented in March 2020 under Section 1915(b) waiver authority of the Social Security Act of 1981, Sec. 1915. [42 U.S.C. 1396n]. As of February 2024,[5] MHP serves approximately 26,240 children and youth in the following populations:

- Children and youth in foster care or the adoption assistance program, which includes kinship care and legal guardianship.
- Children ages three to 21 who are concurrently enrolled in the West Virginia Children with Serious Emotional Disorders (CSEDW) 1915(c) Waiver, which provides an array of HCBS services that enable children to remain in their home and community.

The BMS is also working with the CMS to gain approval in SFY 2025 to enroll former foster care youth up to age 26 years in the MHP program.

The BMS contracts with one MCO for the provision and coordination of MHP services. The BMS and the MHP MCO also coordinate with the West Virginia Bureau for Social Services and the Office of Inspector General's Foster Care Ombudsman to support the MHP population and to advocate for the rights of eligible children and youth across programs and State agencies. Additionally, the Office of Constituent Services provides support in the form of prompt and accurate reporting services for questions regarding member benefits.

1.2 BMS Office of Quality Management and Collaboration with Stakeholders

The OQM has the primary responsibility for managed care oversight and quality management. The BMS Center for Managed Care Director and coordinate closely with the OQM to achieve quality-related goals for the MHT and MHP programs. The BMS organizational chart is found in Appendix D.

The OQM leads collaboration with internal and external stakeholders to develop quality initiatives and seek input to ensure delivery of evidence-based, high-quality health care services. OQM partners with numerous stakeholders, including advocates, legislators, providers, MCOs, and the BMS enrollment broker. BMS also works with representatives from other state agencies, as needed, to raise issues of concern to their constituencies and share information about the managed care programs for their staff and members. BMS convened a stakeholder workgroup specific to the development and review of this updated Managed Care Quality Strategy. The workgroup composition, structure, and activities are further detailed in Section 2.

The BMS Medical Services Fund Advisory Council (MSFAC) meets quarterly to provide input on the direction of managed care quality activities and in accordance with 42 CFR §431.12. The MSFAC includes providers, members, legislators, and agency staff, who meet on a quarterly basis to advise the BMS on a range of issues, including providing feedback on quality activities and programs.

Historically, WVCHIP's Board of Directors supported the WVCHIP program by developing plans to provide health services specific to the needs of children. WVCHIP's Deputy Commissioner engaged the Board of Directors in activities critical to the administration of the WVCHIP,

[5]Ibid

including implementing policies and procedures, as well as monitoring financial, quality, and care delivery metrics. The BMS is reconfiguring the WVCHIP Board of Directors to align more closely with MSFAC.

The CSEDW Quality Improvement Advisory (QIA) Council utilizes an evidence-based Quality Improvement System and incorporates a broad base of stakeholders in active roles in the process. These activities are further described in Section 4.

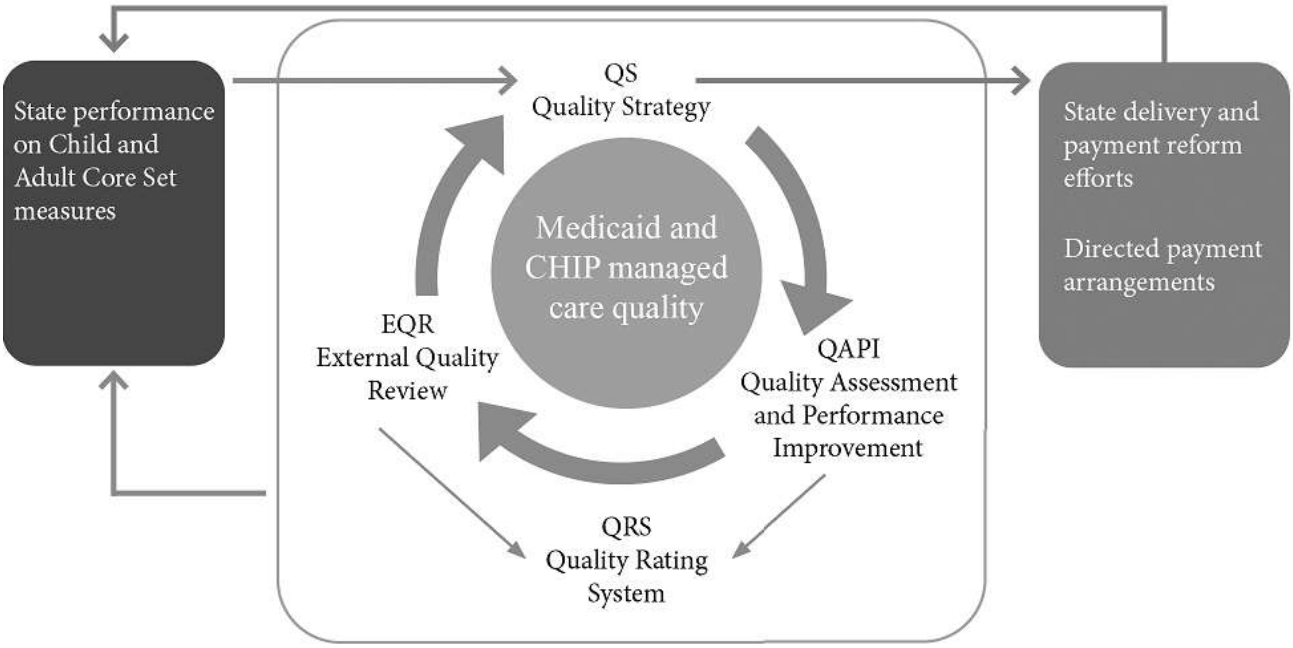
West Virginia does not have federally recognized tribes located in the state; therefore, BMS does not receive consultation from tribal representatives on the Managed Care Quality Strategy as required in 42 CFR §438.340.

Section 2: Development, Review, and Revision of Managed Care Quality Strategy

The BMS developed this Managed Care Quality Strategy in accordance with 42 CFR §438.340 and 42 CFR §457.1240. To ensure compliance with the regulatory requirements in the 2021 CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit, Appendix A provides a crosswalk of each required element and the corresponding section of the Managed Care Quality Strategy where the element is located.

According to the CMS, the quality strategy is part of a multipronged approach to managed care quality, which is best implemented when aligned with use of other key quality tools and initiatives such as the Medicaid and CHIP Adult[6] and Child[7] Core Set measure reporting; NCQA HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[8] reporting; PIPs, as part of Quality Assessment and Performance Improvement (QAPI) programs; value-based purchasing initiatives; and annual External Quality Review (EQR).[9] As illustrated in *Figure 3*, These tools and initiatives are interrelated, with each one informing and reinforcing the others.[10]

Figure 3: Relationship between State Medicaid and CHIP Managed Care Quality Initiatives



[6] More information about the Medicaid Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html
[7] More information about the Medicaid and CHIP Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html
[8] CAHPS® assesses health care quality by asking patients to report their experiences with care rendered by health plan providers.
[9] See 42 CFR 438.330, 438.334, 438.6(c), 438.350, 42 CFR 457.1240(b), 457.1240(d), and 457.1250 for more information on QAPI, state directed payments, and EQR.
[10] Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit, June 2021 https://www.medicaid.gov/sites/default/files/2021-12/managed-care-quality-strategy-toolkit.pdf

2.1 Process for Reviewing and Updating the Managed Care Quality Strategy

The OQM is responsible for maintaining and updating the State's Medicaid and WVCHIP Managed Care Quality Strategy. The OQM, in consultation with a multidisciplinary group of stakeholders, developed the key priority areas and measures included in this Managed Care Quality Strategy. The BMS updates the Managed Care Quality Strategy for the CMS review on a triennial basis, or more frequently when there is a significant change to the Medicaid and/or WVCHIP programs. The BMS defines a significant change as the following:

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

The OQM is responsible for reviewing program changes to determine the level of significance and if revisions to the Managed Care Quality Strategy are necessary.

The BMS formally assesses the Managed Care Quality Strategy annually to track progress toward meeting goals and objectives. The State reviews recommendations of its contracted External Quality Review Organization (EQRO) to identify areas of deficiency and approaches to improve the quality, appropriateness, and access to health care services for Medicaid and WVCHIP members. The EQRO is also instrumental in identifying performance measures that best reflect the State's goals. The BMS also takes into account the MCO's QAPI programs and the MCO reporting when updating the Managed Care Quality Strategy. The BMS reviews available data throughout the year to address early warning signs or issues that arise.

2.1.1 Stakeholder Workgroup

The process for developing the Managed Care Quality Strategy promotes meaningful improvement in clinical and preventive health affecting West Virginia Medicaid and the WVCHIP members. It also provides a wide range of stakeholders with the opportunity to review and provide feedback. In November 2023, the BMS convened a stakeholder workgroup that consisted of representatives from the BMS (inclusive of WVCHIP), MCOs, Bureau for Public Health (BPH), Bureau for Behavioral Health (BBH), and Bureau for Social Services (BSS). The workgroup assisted in review of required quality strategy elements and analysis of the 2024-2027 Managed Care Quality Strategy to provide recommendations for selection of meaningful measures applicable to the populations served that align with the State's priorities and the CMS strategies.

2.1.2 Public Comment

The BMS actively seeks input from members and other stakeholders on the Managed Care Quality Strategy draft through a public comment period. The draft Managed Care Quality Strategy was posted to the BMS website in April 2024, in accordance with federal regulations for public notice and availability of information, allowing a minimum of 30 days for stakeholder input and written feedback. Stakeholder feedback is considered closed after the public comment period has ended.

Section 3: Goals and Objectives

The BMS has established clear goals and objectives for the Managed Care Quality Strategy which are intended to drive specific, measureable, and attainable improvements in care delivery and outcomes. These goals and objectives were selected in collaboration with stakeholders to reflect the needs of West Virginia's Medicaid and WVCHIP populations. West Virginia is a rural state and the only state in the nation completely within the Appalachia region. The West Virginia population totals approximately 1.77 million.[11] Medicaid and WVCHIP covers an estimated 612,000[12] individuals, which is nearly a third of the state's population. The State faces challenges in a number of largely preventable areas such as high substance use disorders (SUD)[13], high prevalence of chronic conditions,[14] and poor ranking in lifestyle habits and health outlook. In addition to these national trends, West Virginia faces other obstacles unique to the Mountain State. According to a 2023 Centers for Disease Control and Prevention (CDC) report of resident deaths, West Virginia had the third highest age-adjusted mortality rate per 100,000 people for all causes. West Virginia also had the highest age-adjusted mortality rates for all accidental deaths, diabetes, and drug overdose deaths.[15,16,17] The goals and objectives outlined in the Managed Care Quality Strategy focus on addressing these avoidable health conditions that affect some of the most vulnerable populations in the State: children, the elderly, and the under-employed.

The BMS crafted five goals to address West Virginia's health challenges and to align with goals identified by the National Quality Strategy[18] to improve quality and health outcomes across the care continuum. The BMS also identified specific objectives with the intent of increasing focus for targeted progress in achieving each goal. Together, the goals and objectives create a framework for West Virginia to drive the overall vision for advancing quality health care among Medicaid members. Table 1 below represents the West Virginia Managed Care Quality Strategy Goals and Objectives for 2024-2027.

[11] U.S. Census July 1, 2023 population estimates.
[12] Medicaid and WVCHIP enrollment data is inflated due to continuous coverage during the federal public health emergency. As the State returns to regular operations, BMS expects enrollment data to decline.
[13] DHHR releases 2016 West Virginia Overdose Fatality Analysis. (n.d.). https://dhhr.wv.gov/News/2018/Pages/DHHR-Releases-2016-West-Virginia-Overdose-Fatality-Analysis-.aspx
[14] America's Health Rankings | AHR. (n.d.) America's Health Rankings. https://www.americashealthrankings.org/learn/reports/2021-annual-report/state-summaries-west-virginia
[15] Centers for Disease Control and Prevention Wonder Data. (2023, February 10). Stats of the states - accident mortality. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/pressroom/sosmap/accident_mortality/accident.htm
[16] Centers for Disease Control and Prevention Wonder Data. (2023a, March 1). Drug overdose mortality by State. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm
[17] Centers for Disease Control and Prevention Wonder Data. (2023b, March 1). Stats of the states - diabetes mortality. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/pressroom/sosmap/diabetes_mortality/diabetes.htm
[18] CMS National Quality Strategy Accessed on January 31, 2024. Retrieved from: https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy

Table 1: West Virginia 2024-2027 Managed Care Quality Strategy Goals and Objectives

Goal		Objectives
	**Goal 1: Improve the health and wellness of the state's Medicaid and the WVCHIP populations through use of preventive services.**	• **Objective 1:** Increase number of enrollees receiving preventive care to meet or exceed the NCQA Quality Compass National Medicaid Average. • **Objective 2:** Increase number of enrollees attending well and preventive visits to meet or exceed the NCQA Quality Compass National Medicaid Average. • **Objective 3:** Increase usage of timely maternal and child health services.
	**Goal 2: Reduce burden of chronic disease.**	• **Objective 1:** Increase number of enrollees receiving treatment for respiratory conditions to meet or exceed the NCQA Quality Compass National Medicaid Average. • **Objective 2:** Increase number of enrollees receiving diabetes care to meet or exceed the NCQA Quality Compass National Medicaid Average. • **Objective 3:** Increase number of enrollees receiving treatment for hypertension to meet or exceed the NCQA Quality Compass National Medicaid Average.
	**Goal 3: Improve behavioral health outcomes.**	• **Objective 1:** Increase number of enrollees receiving follow-up care after behavioral health treatment to meet or exceed the NCQA Quality Compass National Medicaid Average. • **Objective 2:** Increase number of enrollees receiving behavioral health care and treatment.
	**Goal 4: Reduce burden of the SUD.**	• **Objective 1:** Increase number of enrollees receiving treatment for SUD to meet or exceed the NCQA Quality Compass National Medicaid Average. • **Objective 2:** Improve coordination of care for enrollees receiving the SUD treatment.
	**Goal 5: Provide supports for whole-person wellness and empower individuals to self-manage their health.**	• **Objective 1:** Increase number of enrollees receiving smoking cessation services to meet or exceed the NCQA Quality Compass National Medicaid Average. • **Objective 2:** Increase number of enrollees receiving weight management counseling to meet or exceed the NCQA Quality Compass National Medicaid Average.

Goal 1: Improve the Health and Wellness of the State's Medicaid and the WVCHIP Populations through Use of Preventive Services.

Timely preventive care helps drive improvements in health outcomes and reduces future burdens on the health care system. For example, the Early and Periodic Screening, Diagnostic and treatment (EPSDT) benefit provides health care services for children under 21, who are enrolled in Medicaid and the WVCHIP, and is key to ensuring West Virginia's Medicaid population receives appropriate and timely preventive services.[19] As the EPSDT services have been historically underutilized in the state, the BMS continues to implement interventions to improve access to and use of these services. Approximately 65 percent of children in the state receive Medicaid or the WVCHIP coverage; therefore, increasing use of these services is vital to the State's health outcomes.[20]

Additionally, many avoidable health conditions can be prevented by receiving timely immunizations during well-visits. Vaccination rates for adolescent Medicaid members decreased from 29.7 percent in 2020, to 24.5 percent in 2023, emphasizing the importance of focusing on improving vaccination rates among West Virginia's Medicaid population.

Among West Virginia's Medicaid population, breast cancer screenings for ages 50-64 have decreased by 7.8 percent between 2019 and 2022. Additionally, approximately 29 percent of West Virginia seniors had cancer during their lifetime.[21] BMS is committed to improving timely access to cancer screening services for its Medicaid population.

Lastly, BMS aims to address maternal health by improving timely access to prenatal and postpartum care services. Medicaid pays for approximately half of the births in West Virginia, highlighting the importance of improving health outcomes for this population.

Goal 2: Reduce Burden of Chronic Disease.

The BMS seeks to address Goal 2 by focusing on some of the most pressing chronic conditions affecting Medicaid and the WVCHIP members. West Virginia ranks second worst in the nation for disease risk factors and prevalence. According to the CDC, West Virginia has the third highest chronic lower respiratory disease mortality rate (60.07 deaths per 100,000 state residents) and the highest diabetes mortality rate (41.7 deaths per 100,000 state residents), in a three year average from 2019-2021.[22] Among West Virginia Medicaid members aged 18 and over, 15.7 percent had a diagnosis of type 1 or type 2 diabetes in 2023, compared to the U.S. population average of 11.6 percent.[23] Furthermore, West Virginia has the second highest kidney disease mortality rate (21.07 deaths per 100,000 state residents) and the second highest percentage of adults with high blood pressure (43.4 percent) of all states.[24]

As a result, the BMS has selected goals and objectives to specifically assess progress related to these chronic conditions. Additionally, the BMS requires the MCOs to implement disease management programs focused on chronic conditions such as asthma and chronic obstructive pulmonary disease (COPD). For example, one MCO provides one-on-one asthma education and a

[19] https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html
[20] WVCHIP Enrollment Report January 2023 accessed at: https://chip.wv.gov/SiteCollectionDocuments/012023%20Enrollment%20Report%20with%20RAPIDS%20Data.pdf
[21] https://dhhr.wv.gov/hpcd/FocusAreas/wvcancer/Pages/WV-Cancer-Statistics.aspx
[22] Ibid
[23] Centers for Disease Control and Prevention Diabetes percentage among U.S. population aged 18 and older, 2001 – 2021.
[24] Ibid

peak flow meter for its members. Another MCO offers scholarships to Camp Catch Your Breath, a summer camp for members between the ages of eight to 13 with asthma.

Goal 3: Improve Behavioral Health Outcomes.

Improving behavioral health outcomes among West Virginia's Medicaid and the WVCHIP population is a focus for the BMS, as Medicaid shares a disproportionate cost for mental health services. According to the most recent data from the Kaiser Family Foundation, 34.3 percent of adults who experienced mental illness are covered by Medicaid, compared to 21.6 percent nationally.[25] In West Virginia, 33.3 percent of all Medicaid members aged 18-64 had a diagnosis of mental illness in 2023.[26] The BMS is committed to improving health outcomes for members experiencing behavioral health diagnoses by improving timely access to care and follow-up for this population.

Goal 4: Reduce Burden of the SUD.

The opioid epidemic continues to be a prevalent issue throughout the nation and in West Virginia. In 2021, over 106,000 reported deaths in the United States were due to drug overdose, which is the highest on record.[27] Drug overdose deaths have increased in West Virginia from 36.3 deaths per 100,000 to 90.9 deaths per 100,000 between 2011 and 2021. Additionally, nearly 84 percent of fatal overdoses reported by the State between March 2021 and March 2022 included an opioid, and nearly 96 percent of those overdoses included a synthetic opioid, such as fentanyl, which can be deadlier than natural opioids. [28] Combatting the opioid epidemic in West Virginia remains a top priority for the State, and the BMS continues to explore avenues to accomplish this goal. The CDC reported that West Virginia saw a four percent decrease in overdose deaths since 2020.[29] While progress is being made, there are still significant challenges that require focused attention.

The BMS continues to prioritize efforts to address the SUD prevention and treatment and will work collaboratively with the MCOs to collect data and track performance on measures to assess the impact of the SUD-related programs and interventions. The BMS has prioritized measures aimed at treatment and recovery efforts to align with the BMS priorities around the SUD efforts, such as emphasizing prevention, community engagement, support, and research as integral components of the State's approach to combatting the SUD.

Goal 5: Provide Support for Whole-Person Wellness and Empower Individuals to Self-Manage their Health.

West Virginia's population continues to be challenged by lifestyle risk behaviors. Approximately 25.2 percent of West Virginians are current smokers, which is the highest reported rate in the

[25] Kaiser Family Foundation National Survey on Drug Use and Health (NSDUH), 2018 and 2019. https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/west-virginia/
[26] Office of Quality Management Medicaid Data, 2023.
[27] https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/west-virginia/#:~:text=As%20shown%20in%20the%20figure%20below%2C%20drug%20overdose%20death%20rates,per%20100%2C000%20in%20the%20U.S.
[28] https://dhhr.wv.gov/office-of-drug-control-policy/newsannouncements/Pages/Test-News-Item-2.aspx
[29] Ibid

nation.[30,31] The State also leads the nation in adults with obesity, at 41 percent.[32] The BMS aims to empower members to take an active role in managing their health and wellness by improving access to tools such as tobacco cessation programs, weight assessment and counseling, and nutritional guidance. Recognizing that lifestyle changes often take place at the community level, the BMS has tasked the MCOs with prioritizing the collection and use of the Social Determinants of Health (SDoH) data. In doing so, the BMS is targeting opportunities to improve available mechanisms for capturing health-related social needs data and providing closed-loop referrals.

In partnership with the MCOs and West Virginia stakeholders, the OQM selected quality measures to drive and measure progress toward these selected goals and objectives. Appendix B provides a detailed list of quality measures, thresholds, and performance targets to be achieved over a three-year period. Monitoring activities are further described in Section 4 and include the EQRO Annual Technical Report (ATR) findings, compliance monitoring, and working with the MCOs on corrective action, as appropriate, to ensure a commitment to continuous quality improvement.

[30]West Virginia Division of Tobacco Prevention, 2022. Retrieved from: https://dhhr.wv.gov/wvdtp/Cessation/Pages/default.aspx#:~:text=West%20Virginia%20Tobacco%20Use%20Statistics,%25%20(BRFSS%2C%202022).

[31] Behavioral Risk Factor Surveillance System (BRFSS), 2022. Survey Data and Documentation. Retrieved from: https://www.cdc.gov/brfss/annual_data/annual_2022.html

[32] Behavioral Risk Factor Surveillance System (BRFSS), 2022. Adult Obesity Prevalence Maps. Retrieved from: https://www.cdc.gov/obesity/data/prevalence-maps.html

Section 4: Assessment

The BMS evaluates the quality of care delivered to members in the MHT and MHP managed care programs through multiple methods of assessment, including the following:

- **Quality and Appropriateness of Care:** The BMS has policies and procedures in place to ensure that all of the MHT and MHP members receive high quality care, including those with special health care needs. The BMS and the MCOs evaluate data by age, race, ethnicity, and primary language spoken to create plans to eliminate health disparities.
- **Performance Measurement:** The BMS requires the MCOs to collect and report measures from the NCQA HEDIS®, CAHPS® surveys, and the Adult and Child Core Set Measures.
- **External Quality review:** The BMS contracts with an EQRO to conduct independent evaluations of MCO performance, in accordance with federal regulations.

These assessment activities, detailed in the following sub-sections provide tools for the BMS to evaluate progress on the Managed Care Quality Strategy goals and objectives.

4.1 Evaluation of the Quality and Appropriateness of Care

The BMS established this Managed Care Quality Strategy to include assessing and improving the quality of health care and services furnished to the MHT and MHP members under the MCO contracts as required by 42 CFR §438.340 and 42 CFR §457.1240(e).

4.1.1 Identification of Age, Race, Ethnicity, Language, Disability Status, and Special Health Care Needs (438.340(B)(6), 438.208 & 438.340)

The BMS collects information on member race, ethnicity, and primary language during the initial determination of Medicaid and WVCHIP eligibility and provides this information to the MCOs as part of the enrollment file. The enrollment file also identifies individuals who have qualified for Medicaid because of their disability status. "Disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability[33] (i.e., Supplemental Security Income (SSI) beneficiaries). The MCOs collect updated information from members when conducting initial health risk assessments or at other touchpoints. The MCOs are contractually required to collect and meaningfully use member-identified race, ethnicity, language, and SDoH data to identify and reduce disparities in health care access, services, and outcomes. The MCO must consider information about SDoH, as identified by bodies including, but not limited to the CDC for care coordination services.

Medicaid and the WVCHIP have mechanisms to identify persons with special healthcare needs, defined as individuals with complex or serious medical conditions who also require health and related services of a type or among beyond what is generally required. Identification is a multi-step process. The enrollment broker identifies adults and children with special health care needs during the health assessments conducted as part of the enrollment process and provides the information, along with copies of the health assessment forms, with the MCO enrollment rosters. The MCOs must also have procedures for identifying individuals with complex or serious medical conditions.

[33] For purposes of 42 CFR 438.340(b)(6) (applicable also to CHIP managed care programs per 42 CFR 457.1240[e]), "disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability.

Following, we further describe how the BMS uses this data to assess progress on meeting the goals and objectives of this Managed Care Quality Strategy and the impact to identified measures.

4.1.2 Assessing Quality and Appropriateness of Care for Members with Special Health Care Needs

The BMS monitors regular reporting from the MCOs to assess quality of care provided to members with special health care needs. Quarterly reporting on metrics such as utilization, claims, grievance and appeals, access, and networks are broken out by eligibility category so that members who have coverage based on SSI disability can be analyzed separately.

Each MCO's QAPI must include mechanisms to detect both underutilization and overutilization of services and to assess the quality and appropriateness of care provided to members with special health care needs. The MCOs must use appropriate healthcare professionals in assessing those conditions, identifying medical procedures to address and/or monitor the conditions, and developing treatment plans appropriate for those members determined to need a course of treatment or regular care monitoring.

The QIA Council discovery and remediation activities focus on the collection of data necessary to monitor quality indicators established to provide evidence related to the CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, people/family focus groups and interviews, and other stakeholder feedback and input.

4.1.3 West Virginia Disparities Plan

The BMS is committed to reducing health disparities that exist across the Medicaid and the WVCHIP populations. The State analyzes data across age, sex, ethnicity, race, and disability status to identify disparities and design quality improvement interventions. To this end, the BMS has incorporated robust provisions in the MHT and MHP managed care contracts to address health disparities. The MCOs are required to hire a Health Equity director as part of their key staff. They must also establish a Health Equity and Quality Committee to monitor and improve population health outcomes, including addressing health equity and the SDoH to assess overall health plan performance. This Committee is chaired by the MCO's Health Equity director and involves members, network providers, and stakeholders, as appropriate. Activities include establishing initiatives to further health equity among members, developing strategies to address the SDoH, and improving their ability to collect and use data to reduce disparities in healthcare access, services, and outcomes.

The MCOs must maintain accreditation from NCQA for their Medicaid and WVCHIP lines of business. To facilitate delivering equitable health services, the BMS requires MCOs to adopt strategies to simplify administrative procedures, per the NCQA Health Equity Accreditation or Health Equity Accreditation Plus programs.

4.2 Performance Measurement

4.2.1 National Performance Measures:

Performance measurement is key to monitoring and improving quality. To the extent possible, the BMS relies on national performance measures that support comparisons and benchmark performance against other national, state, and local entities. The BMS requires the MCOs to report relevant measures included in the NCQA HEDIS®, NCQA CAHPS®, 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. Specifically, the MCOs must collect and report measures in the following areas:

- Screening and preventive care.
- Chronic care.
- Access, availability, and timeliness of care.
- Utilization.
- Member satisfaction measures.

In the event that the CMS or NCQA adopts additional performance measures, the BMS will incorporate them into the Managed Care Quality Strategy. Requirements for MCO performance measures and levels are contained in the MCO contracts. The BMS selected measures for the Managed Care Quality Strategy primarily from these data sets. National measures with defined technical specifications ensure consistency in reporting and allow West Virginia to benchmark performance against other Medicaid and the CHIP programs.

4.2.2 MCO Reporting

The MCOs are required to submit monthly, quarterly, annual, and ad-hoc reports as described in the program's respective the MCO contracts. The BMS reviews reporting to monitor the MCO operations and performance on an ongoing basis. This monitoring enables the BMS to identify potential issues in a timely manner and work with the MCO to resolve. For example, a number of MCO reports give the BMS insight into changes in network or primary care provider (PCP) panel sizes that could affect members' access to care. The BMS monitors fraud, waste, and abuse activities, claims, and high priority mental health and the SUD services on a monthly basis. Quarterly reporting provides insight into MCO operations, networks, membership, and utilization. As part of the annual review of the Managed Care Quality Strategy, The BMS reviews the MCO QAPI plans.

4.3 External Quality Review Activities and Process

The BMS contracts with an EQRO[34] 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 required and three optional EQR activities, in accordance with the CMS EQR protocols. *Table 2* summarizes the EQR activities performed.

Table 2: External Quality Review Activities

Required Reporting	Optional Activities
1. Systems Performance Review. 2. Performance Measure Validation. 3. Performance Improvement Projects. 4. Network Adequacy Validation.	1. 24/7 Access to Care Standard Evaluation. 2. Encounter Data Validation. 3. Grievance/Appeals/Denials Review.

The EQRO produces a CMS-mandated ATR that summarizes results from all of the EQR activities and includes:[35]

- Results of the EQR-related activities.
- EQRO's assessment of each MCO's strengths and weaknesses related to quality, timeliness, and access.
- Recommendations for improving the quality of health care services furnished by each MCO and recommendations for how the State can target goals and objectives in the Managed Care Quality Strategy.
- Methodologically appropriate, comparative information about all of the MCOs.
- Assessment of the degree to which each MCO has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

The EQR activities provide assurance and confidence that MCO-reported data is accurate and comprehensive. BMS relies on the findings to identify areas for improvement, track progress on Managed Care Quality Strategy goals, and define future areas of focus. The BMS works closely with the EQRO to select the strategy's objectives and performance measures. The WV Annual Technical Reports are published on the BMS website. The EQR activities overlay the monitoring and quality improvement activities performed by the BMS.

4.3.1 Non-Duplication of Standards (42 CFR §438.360 and 42 CFR §457.1250)

The CMS "non-duplication" regulation gives states the authority to use information obtained from a private accreditation review source, such as the NCQA, to demonstrate compliance with the State's EQR operational review standards. States can deem private accreditation organization

[34] BMS is contracted with Qlarant to perform External Quality Review Organization activities.

[35] *Quality of Care External Quality Review | Medicaid*. (n.d.). Accessed on January 19, 2024. Retrieved from: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/quality-of-care-external-quality-review/index.html#:~:text=The%20annual%20EQR%20technical%20report%20is%20the%20public%20facing%20end,either%20in%20print%20or%20electronically.

standards as equivalent to state standards to prevent the duplication of mandatory compliance reviews.

The CMS currently supports the non-duplication approach for one or more of the three mandatory EQR related activities: the PIPs, validation of performance measures, and review of compliance with Medicaid managed care regulations. To do so, the following conditions must be met:

1. The MCO is in compliance with the applicable Medicare Advantage or private accreditation standards.
2. The Medicare or private accreditation review standards are comparable to those established through the EQR protocols for the three mandatory EQR-related activities.
3. The MCO provides the State with all applicable reports, findings, and other results of the Medicare or private accreditation review applicable to the specified EQR-related activities.

The BMS requires participating MCOs to seek and maintain the NCQA accreditation. The EQRO reviews the Medicare, Medicaid, and CHIP standards for instances where structural and operational standards overlap. Such areas for overlap may include credentialing and re-credentialing procedures, using practice guidelines, reporting processes to the MCO Board of Directors, and approval of the Quality Improvement Committee. In cases where the state or federal standard is less stringent than the NCQA requirement, the BMS can use NCQA's assessment in place of the EQR compliance review.

Deemable elements for non-duplication are provided in Appendix E.

Section 5. Federal and State Standards

The BMS regularly assesses the 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 as they establish an infrastructure to promote high-quality, accessible care. The BMS employs prospective, concurrent, and retrospective methods to assure compliance with managed care quality standards, detailed in *Table 3*.

Table 3: Methods for Determining Compliance with Federal and State Quality Standards

Method Type	Compliance Monitoring Activities
Prospective Methods	• The MCO certification. • The MCO contracts with the state of West Virginia. • Review of the MCO provider network. • West Virginia State Insurance Commission MCO licensing.
Concurrent Methods	• Review of the MCO quarterly operational reports and encounter data. • Monitoring of enrollment broker activities, including disenrollment.
Retrospective Methods	• Annual external review including compliance review, validation of performance measurements, validation of performance improvement projects, network validation, encounter data validation, 24/7 access standard evaluation, review of grievance/ appeals/denial data. • Review of the NCQA HEDIS® and CAHPS® results. • Review of the MCO annual reporting.

The BMS uses these monitoring activities to determine whether the MCOs meet the minimum required standards of the MHT or MHP programs, commensurate with state and federal laws and regulations. The MCO contracts for each program describes minimum standards and are compliant with all of the current Medicaid and CHIP managed care regulations.

5.1 Access and Availability Standards

5.1.1 Availability of Services ((§438.206 and §457.1230)

Through its MCO contracts, the BMS requires all applicable services covered under the Medicaid State Plan and WVCHIP State Plan be available and accessible to managed care members. The MCOs provide to members, directly or through arrangements with subcontractors, all covered services described in the MCO contract. The MCOs are required to coordinate with State Plan services covered under FFS, including pharmacy and NEMT services, and ensure that members can access these services.

The MCOs are required to submit quarterly assurance of adequacy through a PCP panel and specialist availability report. On an annual basis, the BMS requires MCOs to submit their full provider network analysis for re-evaluation. The BMS measures the networks by comparing against established network adequacy standards.

5.1.2 Network Adequacy Standards (§438.68 and §457.1218)

The BMS requires the MCOs to maintain provider networks in geographically accessible locations and sufficient numbers to provide all covered services in a timely manner. The MCO contracts identify the minimum standards for the MCO's provider network and is further detailed in Appendix F.

Network standards include provider-to-enrollee ratios and travel time and distance requirements. The provider-to-enrollee ratios ensure that the 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.

To meet access requirements, the MCOs must meet the defined provider-to-enrollee ratios and time and distance standards in every county. In calculating provider-to-enrollee 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.

In accordance with 42 CFR §438.206(c)(iii),when medically necessary, the MCO must make services available 24 hours a day, seven days a week and establish a mechanism to ensure that providers comply with the access standards set forth in the MCO contract. The MCOs must regularly measure the extent to which network providers comply with these requirements and take remedial action if necessary. The BMS also contracts with the EQRO to perform an audit of the MCO compliance with access to care.

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

The MCOs must establish and maintain provider networks that have the capacity to provide all covered services to its membership. These networks must be comprised of hospitals, PCPs, dental, and specialty care providers sufficient numbers to make available all covered services in adequate amount, duration, and scope to reasonably achieve its purpose. In accordance with 42 CFR §438.207, the MCOs must maintain a sufficient number, mix, and geographic distribution of providers.

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

The BMS requires the MCOs to provide an integrated approach to coordination and continuity of care, including procedures to deliver primary care to and coordinate health care service for all the MCO members. The MCOs must ensure that each member has an ongoing source of primary care. In addition to coordination of covered services, the MCOs are required to have programs that include coordination with social and community services to address members' whole needs. The BMS details continuity of care requirements in the MCO contract.

5.1.5 Transition of Care Policy (§438.62 and §457.1216)

The BMS requires that each MCO has a transition of care policy that minimizes gaps in services and streamlines transitions for members. The MCOs must have a transition of care policy to ensure continued access to services during a transition to or from FFS to an MCO, 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 the 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.

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

The BMS ensures 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.

5.2 Structure and Operation Standards

5.2.1 Subcontractual Relationships and Delegation (§438.230 and §457.1233)

With the BMS approval, the MCOs may enter into subcontracts for the provision of covered services to managed care members. The BMS ensures through their contracts that each MCO complies with requirements regarding subcontractual relationships and delegation.

5.2.2 Provider Contracting (§438.214 and §457.1233)

The BMS requires through their contracts that each MCO implements written policies and procedures for selection and retention of providers. In compliance with state and federal regulations, The BMS established a uniform credentialing and re-credentialing policy that each MCO must follow. The MCO contracts contain detailed MCO credentialing requirements.

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

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

5.2.4 Enrollee Information (§438.10 and §457.1207)

BMS requires that MCOs inform enrollees 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 and 42 CFR §457.1207.

5.2.5 Confidentiality (§438.224 and §457.1110)

BMS requires 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.

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

BMS requires 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. The State and EQRO collect and review quarterly grievances, denials, and appeals information from the MCOs. They conduct annual audits of the grievances and appeals reports and MCO processes to ensure compliance with regulations and timeframes.

BMS delegates responsibility for notice of action to the MCO under 42 CFR §431 Subpart E of this chapter. BMS, or its 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.

5.3 Health Information Systems and Information Technology (42 CFR §438.242 and §457.1233(d))

A strong health information technology infrastructure drives quality improvement by enabling continuous quality monitoring, assessment, and improvement activities. The BMS is committed to investing in information systems that support Medicaid and WVCHIP programs operations. The State maintains an eligibility and a claims processing system (Medicaid Management Information System [MMIS]) and a managed care enrollment system.

5.3.1 Eligibility System

West Virginia is in the process of transitioning from its legacy eligibility system, Recipient Automated Payment and Information Data System (RAPIDS), to an integrated eligibility system, West Virginia People's Access to Help (WV PATH). DoHS programs supported by the WV PATH system include Medicaid, WVCHIP, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF or WV WORKS), and other State-operated assistance programs.

5.3.2 MMIS

MMIS is a shared resource between the BMS and the West Virginia Departments of Health, Health Facilities, and Human Services, and Office of Shared Administration's Office of Management Information Services (MIS). MMIS processes the FFS claims and collects encounter data submitted by the MCOs. The FFS claims includes those services carved-out of the managed care delivery system, such as pharmacy and NEMT services, and excluded from the MCO capitation rates. The encounter data is used in the managed care rate-setting process.

5.3.3 Managed Care Enrollment Information System

The contracted enrollment broker maintains the managed care enrollment information system, which is linked to the MMIS. This system includes information on past and current MHT or MHP enrolled members, including historical MCO assignments, whether individual enrollment in an MCO was voluntary or assigned, and PCP assignments. The enrollment system tracks reasons for disenrollment and member MCO switches. This system also includes information on provider networks, so that the enrollment broker can assist members in selecting a PCP.

5.3.4 Medicaid Enterprise Data Solution (EDS)

The BMS and MIS utilize the EDS which includes the MCO and FFS encounter and eligibility information along with provider information to support reporting, data mining, and program analyses. The EDS replaced the previous Data Warehouse/Decision Support System, with its various components transitioning over several months in early 2022. The OQM utilizes the EDS for some reporting of the Adult, Child, and Health Homes Core Sets of Quality Measures (Core Sets) as well as additional HEDIS® measures outside of the Core Sets. The HEDIS® measures included in the EDS pre-built components are NCQA certified. There are additional data sources, as well as planned data sources, that feed into the EDS for the use of OQM and MIS representatives. Additional measures, that are not HEDIS®, may be included in the pre-built components but not necessarily certified by the measure steward(s).

5.3.5 MCO Information Systems

The BMS requires that each MCO maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of 42 CFR §438.242 and §457.1233(d).

The system must provide information on areas including, but not limited to, utilization, grievances, appeals, and denials and disenrollment for reasons other than loss of eligibility. The MCOs must 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. The BMS reviews all encounter data for timeliness and usability and performs longitudinal analysis to make sure the data is complete and accurate.

5.4 Intermediate Sanctions

The MCO contracts establish intermediate sanctions under certain circumstances as required by 42 CFR §438.700 and 42 CFR §457.1270. The MCOs are allowed due process protections including a notice of sanction (42 CFR §438.710). The managed care contracts inform the MCOs that BMS must notify CMS of any sanctions imposed (42 CFR §438.724). In addition, BMS retains authority to impose additional sanctions at its discretion under State statutes or State regulations (42 CFR §438.702(b)). The BMS 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.

If an MCO does not meet the terms and conditions established in the contract, the BMS has the authority to require corrective action plans (CAPs), impose liquidated damages and other financial penalties, suspend new enrollments, and fail to renew or terminate the contract.

5.5 Measurement and Improvement Standards

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

The BMS requires through their contracts that each MCO complies with requirements regarding practice guidelines. The BMS requires the MCOs to adopt and disseminate evidence-based practice guidelines which must be based on valid and reliable medical evidence or a consensus of health care professionals in the field. Guidelines should consider the needs of the enrolled population and be adopted in consultation with contracting health care professionals and must be reviewed and updated periodically.

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

The BMS ensures that each MCO has an ongoing QAPI program for the services it furnishes to its members. Detailed MCO quality assessment and performance improvement requirements are contained in the MCO contract.

If the CMS, in consultation with states and other stakeholders, directs states to implement new performance measures and/or topics for performance improvement, the BMS will incorporate these performance measures and topics into the QAPI program requirements.

At least annually, the BMS reviews the impact and effectiveness of each MCO's QAPI program. The review includes the MCO's performance on the reported standard measures and the results of each MCO's PIP. The MCOs are required to have a process for their own evaluation of the impact and effectiveness of their QAPIs.

Section 6: Improvement and Interventions

The BMS is committed to improving quality of care by supporting the MCO initiatives, incentivizing providers, and implementing targeted interventions. The MCOs are required to offer disease and care management programs and regularly undertake targeted improvement initiatives. In recent years, the BMS has increased its efforts to engage providers in more value-driven payment arrangements at both the MCO and individual provider level. The BMS will work with the MCOs to ensure the following interventions address the goals and required measures throughout the period of this Managed Care Quality Strategy. These interventions will also provide the BMS with quality-related data for future monitoring and planning.

6.1 Improving Quality of Care through Interventions

6.1.1 Performance Improvement Projects (PIP) 42 CFR §438.330.

Each MCO must conduct annual PIPs designed to make improvements in specific areas of concern. PIPs must be:

- Designed to achieve significant improvement, through ongoing measurements and intervention.
- Sustained over time.
- In clinical care and non-clinical care areas that have a favorable effect on health outcomes and enrollee satisfaction.

The MCOs must initiate and maintain at least three PIPs at a time. At least one PIP must be for a clinical focus area that impacts pediatric members. The topics must be identified through continuous data collection and analysis, systematically selected and prioritized to achieve the greatest practical benefit for members, and reflect the prevalence of a condition among, or need for a specific service by, the MCO's members based on enrollee demographic characteristics, health risks, and any other special needs. The BMS, in consultation with the EQRO, determines topics for two of the current PIPs based on MCO performance, (see *Table 4 – 7*). This does not restrict the MCO from conducting other PIPs as they determine necessary for the health and wellness of their specific enrollment population. The BMS' EQRO validates PIPs to ensure they were designed, conducted, and reported in a methodologically sound manner and meet all State and federal requirements.

Table 4: MHT State Mandated PIPs

MHT State Mandated PIPS			
PIP Topic	**PIP Performance Measure (PM), Steward, and Population**	**PIP Aim**	**PIP Interventions***
Annual Dental Visits (retired on December 31, 2023, replaced with lead screening children)	**PM 1:** Annual dental visits for children 2 to 3 year of age **Measure Steward:** NCQA **Population:** Children 2 to 3 years of age **PM 2:** Percentage of eligible members that received preventive dental services **Measure Steward:** Formerly the CMS* **Population:** Children, adolescents, and adults 1 to 20 years of age	Will implementation of targeted member/provider/MCP interventions improve rates of annual dental visits for members 2 to 3 years of age and eligible members receiving preventive dental services for members 1 to 20 years of age each measurement year?	• **Member incentive.** Provided members with a $25 gift card for completing a dental visit. • **No cost transportation.** Promoted member no cost transportation services via member outreach; gaps in care and case management calls; and member handbook, newsletters, and website. • **Gaps in care education.** Conducted educational provider webinars, which explained why members have gaps in care and provided education on how to close the gaps, including appropriate dental coding. Education included provider best practice descriptions. • **Provider incentive.** Incentivized providers to complete well-child visits and encouraged them to discuss dental care and benefits during these visits. • **Children's wellness club.** Offered exclusive opportunities to members 13 years of age and under to earn prizes by participating in a variety of wellness activities, including oral health and dental care.
Follow-Up After Emergency Department Visit for Mental Illness	**PM 1:** Follow-up after emergency department visit for mental illness – 30-day follow-up (total) **Measure Steward:** NCQA **Population:** Children, adolescents, and adults 6 years of age and older	Will implementation of targeted member/provider/MCP interventions improve 30-day follow-up visit rates for members 6 years of age and older who had an emergency department visit with a principal diagnosis of mental illness or intentional self-harm each measurement year?	Measure Year (MY) 2022 served as the baseline year for this for this PIP. Implementation of interventions is not required until after the baseline year. The MCOs identified member, provider, and MCP barriers and began implementing interventions targeting barriers during 2023. These interventions will be evaluated and reported in the next annual report.

*Summarized list of MCO interventions.

Table 5: MHT MCO Selected PIPs

MHT MCO-Selected PIPS			
PIP Topic	**PIP Performance Measure, Steward, and Population**	**PIP Aim**	**PIP Interventions***
Care for Adolescents	**PM 1:** Immunizations for adolescents – combination 2 **Measure Steward:** NCQA **Population:** Adolescents 13 years of age **PMs 2 and 3:** Child and adolescent well-care visits: • 12 to 17 years of age • 18 to 21 years of age **Measure Steward:** NCQA **Population:** Adolescents and adults 12 to 21 years of age	Will the implementation of member, provider, and MCP interventions increase the rates of adolescent care, including well visits and immunizations received amongst members 9 to 21 of age enrolled in MHP, by the end of the measurement year?	• **Member incentives.** Awarded members 12 to 18 years of age a $25 gift card for completing an annual well-child visit. • **Targeted outreach.** Contacted members enrolled in case management to encourage well-child visits and offered assistance in scheduling appointments. • **No cost transportation.** Promoted member no cost transportation services via member outreach; gaps in care and case management calls; and member handbook, newsletters, and website. • **Provider incentive.** Incentivized providers with $25 for completing and closing their gaps in well-child visits. • **HEDIS® provider toolkit.** Provided provider office staff with HEDIS® measure education, including well-child and immunization-related measures, medical record documentation tips, and coding requirements.
Promoting Health and Wellness in Children and Adolescents	**PM 1:** Child and adolescent well-care visits – total **Measure Steward:** NCQA **Population:** Children, adolescents, and adults 3 to 21 years of age **PMs 2 and 3:** Weight assessment and counseling for nutrition and physical activity for children/adolescents: • Body Mass Index (BMI) percentile documentation. • Counseling for nutrition.	Will member, provider, and MCP interventions focusing on improving children and adolescents' well-being increase rates for the Child and Adolescent Well Care Visits measure and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents BMI and Counseling for Nutrition measures by 10 percentage points over the life of the PIP?	• **Member education.** Contacted member parents/guardians via telephone or postcard and educated them on the importance of well-care visits, COVID-19 safety protocols, and the availability of telehealth services. Information was also communicated through social media posts, the MCO websites, and the Member Handbook. • **Member incentive.** Awarded members who completed an adolescent well-care visit a $25 gift card. • **Provider gap in care reports.** Identified members in need of an annual well-care visit and distributed gap in care reports to PCPs, federally qualified health centers (FQHCs), and rural health clinics (RHCs).

MHT MCO-Selected PIPS			
PIP Topic	**PIP Performance Measure, Steward, and Population**	**PIP Aim**	**PIP Interventions***
	Measure Steward: NCQA **Population:** Children and adolescents 3 to 17 years of age		• **Alternate payment model agreement.** Continued an alternate payment agreement with select providers, which included well-care visits as a targeted area for improvement. • **Transportation notice.** Informed members/parents/guardians of the availability of transportation to care during welcome calls.
Immunizations for Adolescents	**PMs 1 and 2:** Immunizations for adolescents: • Combination 2 • Human Papillomavirus (HPV) **Measure Steward:** NCQA **Population:** Adolescents 13 years of age	Will implementation of member, provider, and MCP interventions increase rates for Immunizations for Adolescents Combination 2 and HPV over the life of the PIP?	• **Member education.** Texted messages to members, which aimed to educate using evidence-based guidelines and describe immunization purpose, safety, and efficacy. Conducted calls to members and mailed EPSDT birthday reminders to encourage members to obtain preventive care and vaccinations. • **Member incentive.** Provided a $50 gift card to members who completed the HPV vaccine series on or before their 13th birthday. • **Provider quality incentive program (expansion).** Expanded an incentive-based program to additional provider groups and included the Immunizations for Adolescents – Combination 2 measure as a key metric. • **Pay for quality.** Incentivized providers to close gaps in care for members receiving one tetanus, diphtheria toxoids and acellular pertussis vaccine, one meningococcal vaccine, and HPV on or before their 13th birthday ($50 per gap closure). • **Provider action plans.** Worked with large primary care groups to develop action plans, interventions, and goals to improve vaccination rates. Gap in care reports are also distributed to the top ten providers with the largest gaps in care. Clinical quality auditors work with providers to improve performance.

*Summarized list of MCO interventions.

Table 6: MHP State Mandated PIPs

MHP State Mandated PIPS			
PIP Topic	**PIP Performance Measure, Steward, and Population**	**PIP Aim**	**PIP Interventions***
Annual Dental Visit	**PM 1:** Annual dental visits for 2 to 3 years of age **Measure Steward:** NCQA **Population:** Children 2 to 3 years of age **PM 2:** Percentage of eligible members that received preventive dental services **Measure Steward:** The CMS **Population:** Children, adolescents, and adults 1 to 20 years of age	Will the implementation of collaborative member, provider, and MCP interventions improve Annual Dental Visit rates among children 2 to 3 of age and preventive dental service's rates, among children 1 to 20 years of age, enrolled in the MHP program, by the end of the measurement year?	• **No cost transportation.** The MCP promoted member no cost transportation services during member outreach, gap in care calls, case management calls, member newsletters, member website, and member handbook. • **Children's wellness club.** Members 13 years of age and under were offered exclusive opportunities to earn prizes by participating in a variety of wellness activities, including oral health and dental care. • **Member incentive.** Members 12 to 18 years of age received a $25 gift card for completing an annual well-child visit. Members 2 to 3 years of age received a $25 gift card for completing an annual dental visit. • **Provider incentive.** Providers were incentivized to complete well-child visits for members 12 to 17 years of age and encouraged to discuss dental care and dental benefits during these visits. • **Gaps in care education.** The MCP delivered Gaps in Care Lunch and Learn webinars, which described best practices and why members have gaps in care, and provided education on how to close the gaps, including appropriate dental coding.
Care for Adolescents	**PM 1:** Immunizations for adolescents (combination 2) **Measure Steward:** NCQA **Population:** Adolescents 13 years of age **PM 2 and 3:** Child and adolescent well-care visits: 12 to 17 year of age and 18 to21 years of age **Measure Steward:** NCQA	Will the implementation of member, provider, and MCP interventions increase the rates of adolescent care, including well visits and immunizations received amongst members 9 to 21 years of age with Aetna Better Health of West Virginia MHP, by the end of the measurement year?	• **No cost transportation.** The MCP promoted member no cost transportation services during member outreach, gap in care calls, case management calls, member newsletters, member website, and member handbook. • **EPSDT mailers.** Members received an annual mailer approximately 42 days prior to their birthday reminding them to schedule their well-child visit. • **Targeted outreach.** Members enrolled in case management received calls from case management staff, who encouraged well-child visits and offered assistance in scheduling appointments.

MHP State Mandated PIPS			
PIP Topic	**PIP Performance Measure, Steward, and Population**	**PIP Aim**	**PIP Interventions***
	Population: Adolescents and adults 12 to 21 years of age		• **Member incentive**. Members 12 to 18 years of age received a $25 gift card for completing an annual well-child visit. • **Provider incentive.** Providers were incentivized to complete well-child visits for members 12 to 17 years of age.

*Summarized list of MCO interventions.

Table 7: MHP MCO Selected PIPs

MHT MCO-Selected PIPS			
PIP Topic	**PIP Performance Measure, Steward, and Population**	**PIP Aim**	**PIP Interventions***
Reducing Out-of-State Placement for Children in Foster Care	**PM 1:** Reducing out-of-state placement for children in foster care **Measure Steward:** Homegrown measure **Population:** Child and adolescent members in foster care	Will implementation of member, provider, and MCP interventions decrease the rate of out-of-state placement for MHP members by the end of the measurement year?	• **Country Road initiative.** Facilitated meetings and collaborated with providers to reduce length of stay in out-of-state placement, and bring youth home. • **Increased provider capacity for children with severe emotional disorders.** Worked to build provider community capacity to offer intensive behavioral health services in the member's home to optimize the transition from placement to home. Expanded virtual provider capacity to support members affected by substance use disorders. • **West Virginia System of Care clinical review.** Coordinated efforts with the West Virginia System of Care to provide a comprehensive, objective, clinical review of designated youth. Out-of-state or at risk of going out-of-state youth are reviewed to determine and reduce gaps in services, barriers to in-state services, and system issues. • **Project Promise integrated case management.** A youth priority list is created and triaged based on placement needs. The list is evaluated weekly to prioritize members in foster care with placement needs. • **Psychiatric residential treatment facility (PRTF) case management.** Provided weekly contact with PRTFs to maintain contact and provide case management services to ensure there are no gaps in care upon discharge.

			Case managers review all members in this level of care and work with the PRTF, State, and guardians on transitions to reduce length of stay and minimize time spent in out-of-state facilities.

*Summarized list of MCO interventions.

The MCO will assess its performance on its selected PIP indicators by collecting and analyzing reliable data on an ongoing basis. The MCO must annually submit performance measurement data to the BMS using the BMS-determined standard measures, including performance measures that may be developed by the CMS. The MCO must also demonstrate that its interventions result in meaningful improvement in its performance, as evidenced in repeat measurements of the quality indicators, specified for each PIP undertaken by the MCO.

The PIPs are deemed successful and may terminate once sustained improvement is achieved. Sustained improvement is acknowledged through the documentation and maintenance of improved indicator performance. After improvement is achieved, it must be maintained for at least one year. The MCO must submit a CAP to the BMS that addresses deficiencies identified in any measurement data.

6.1.2 Quality of Care-Focused Provider Education

The BMS will engage in a collaborative process with participating MCOs to facilitate and oversee the development and implementation of quality of care-focused provider education initiatives. Throughout the process, the BMS and the MCOs will identify opportunities to improve the quality of care rendered by network providers, based on population health metrics, and leverage those opportunities through the development of educational intervention strategies, materials, and guidelines. These interventions will be designed to support providers in their efforts to render the highest quality of care possible and improve health outcomes for their patients. Quality of care-focused provider education strategies will identify a universe of network providers for whom the education developed could be beneficial and establish milestone goals, detailing the percentage of providers in the universe the plan will seek to educate through this initiative and the timeframe in which it plans to conduct education. The BMS will work with MCOs to ensure documentation of education reflects both the name(s) of the individual provider(s) educated and the particular topic being addressed to improve provider accountability.

6.2 Incentivizing Performance

6.2.1 Quality Withhold Program

In 2024, the BMS implemented a performance-related withhold for the MHT program that retains one percent of aggregate MCO capitation payments. The MCOs must achieve performance targets on select quality measures to earn back all or a portion of the withhold. As appropriate, the BMS will work to align performance measures selected for the quality withhold program with those being addressed through the Managed Care Quality Strategy.

6.2.2 Alternative Payment Models (APMs)

The BMS supports a value-based healthcare system with the goal to improve member experience and population health outcomes, contain health care costs through aligned incentives with the MCO and provider partners, and maintain a commitment to continuous quality improvement. To support this effort, the BMS requires the MCOs to adopt APMs that reward the delivery of high-quality and cost-efficient health care. The managed care contract requires the MCOs to implement

the APMs which aim to incentivize providers to focus on the quality of care provided, rather than the volume of services rendered. For example, one MCO offers an incentive payment to providers for reporting SDoH codes. These codes support follow up for members who report health-related social needs and ensure appropriate referrals to community-based programs are provided. The MCOs may also use the APMs to incentivize providers for tangible improvements to performance measures included in the Managed Care Quality Strategy. The MCOs report on their APMs annually and have demonstrated their commitment to alternative payment models.

6.2.3 Directed Payment Program (DPP)

The DPP provides qualifying providers with additional dollars for Medicaid members utilizing their services and focuses more dollars to higher need settings. Created through the 2016 Medicaid managed care final rule, the DPPs allow the State to require the MCOs to pay providers according to certain rates or methods established or "directed" by the State. These payment arrangements can include setting a minimum and maximum payment rate for specific types of health care providers, as well as value-based payment arrangements that seek to advance the State's Managed Care Quality Strategy goals.

The BMS operates two DPPs as part of the MHT program: one aimed at hospitals and academic physicians and another aimed at non-academic physicians employed by or subcontracted with hospitals. The DPPs provide qualifying hospitals with additional dollars for services including inpatient admissions, outpatient services, and physician visits. Payments are based on Medicaid managed care utilization of services at each hospital.

To support the BMS quality goals, providers can earn enhanced directed payments based on their performance on measures including flu vaccinations, care transitions, breast cancer screenings, providing discharge information, and physician communication.

6.3 Targeted Interventions/Strategies

The BMS is working collaboratively with other State agencies and stakeholders to implement a variety of targeted interventions and strategies to improve health outcomes for members. As part of implementation planning and ongoing operations, the BMS and these stakeholders are also working to determine how these interventions and strategies can be maximized to address goals outlined in this Managed Care Quality Strategy. Ongoing monitoring of these programs will provide BMS with data for future monitoring and planning.

6.3.1 Mobile Crisis Intervention (MCI) Services

In September 2023, the BMS received State Plan approval from the CMS to implement MCI services for all Medicaid populations. The BMS is targeting implementation of these services for managed care populations beginning in July 2024. This benefit will provide members experiencing a suspected mental health and/or SUD-related crisis timely intensive supports, stabilization of the crisis event, and time-limited rehabilitation intervention services intended to achieve crisis symptom reduction. The BMS offers a toll-free crisis hotline service and member access to mobile crisis response teams throughout the state, staffed 24 hours per day, seven days a week. Mobile crisis services aim to help members return to previous levels of functioning, develop coping mechanisms to minimize or prevent future crises, and prevent unnecessary institutionalization.[36] The services are an important addition to the delivery system, meeting individuals in their

[36] West Virginia State Plan Amendment 23-0003 Medicaid Community-Based Mobile Crisis Intervention Services Program

communities at in the time of crisis. Intervention services will link members to resources and engage them in treatment that will support long-term success.

Mobile crisis services are in alignment with Goals 3 and 4 of this Managed Care Quality Strategy, which are aimed at improving behavioral health outcomes and reducing the burden of SUDs, respectively.

6.3.2 Certified Community Behavioral Health Clinics (CCBHCs)

West Virginia is one of 15 states selected to receive a one million dollar CCBHC planning grant from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. CCBHCs are clinics with special designations designed to provide a comprehensive range of mental health and substance use services to anyone who requests care, regardless of their ability to pay, benefitting all West Virginians. The CCBHCs ensure 24/7 access to crisis response and medication assisted treatment, among other services. The BMS and the BBH are working diligently to address the State's mental health crisis through implementation of CCBHCs in calendar year 2024.

The CCBHC implementation is in alignment with Goals 3 and 4 of this Managed Care Quality Strategy, which are aimed at improving behavioral health outcomes and reducing the burden of SUDs, respectively. The demonstration is intended to increase access to services and make it easier for individuals to receive comprehensive, evidence-based behavioral health treatment in one place. The CCBHCs will be located in rural and underserved areas of the state and targeted to reaching members who have historically been underserved in an effort to reduce health disparities. The State will partner with the CCBHCs to promote evidence-based practices, workforce development, and recovery-based and trauma-informed models of care.

6.3.3 Drug Free Moms and Babies (DFMB)

The West Virginia Perinatal Partnership developed the DFMB program with funding from the DoHS and other organizations, with an aim to develop an integrated approach to provide the best care for mothers and babies. Originally designed as a four-site pilot project, the program has grown to 20 clinical sites serving more than 4,000 women. Evaluation of the program has shown a significant reduction in illicit substance use by participants as well as improved birth outcomes for their children.[37]

The program is in alignment with Goals 3, 4, and 5 of this Managed Care Quality Strategy, which are aimed at improving behavioral health outcomes, reducing the burden of SUD, providing supports for whole-person wellness, and empowering individuals to self-manage their health.

6.3.4 Maternal Opioid Misuse Model

West Virginia was one of 10 states in the nation to receive funding through the CMS Innovation Center to address opioid use disorder among pregnant and postpartum women. In partnership with Marshall Health and the West Virginia Perinatal Partnership, the BMS aims to integrate maternity and behavioral health care. This initiative builds on the success of the DFMB program and aligns with Goals 3 and 4 of this Managed Care Quality Strategy, which are aimed at improving behavioral health outcomes and reducing the burden of SUDs, respectively. The program further aligns with the Managed Care Quality Strategy objective to increase usage of timely maternal and child health services.

[37] *Office of Drug Control Policy Drug Free Mom and Babies (DFMB).* (n.d.). https://dhhr.wv.gov/office-of-drug-control-policy/newsletters/Pages/Drug-Free-Mom-and-Babies.aspx

6.3.5 SDoH

The SDoH includes 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 WVCHIP populations to improve long-term health outcomes and reduce disparities. The BMS uses the enrollment broker's initial contact with members to begin identifying the SDoH needs prior to enrollment in an MCO. The enrollment broker provides this information to the MCOs, which are also using other mechanisms, such as initial health risk assessments and annual reassessments, to further identify member needs. The MCOs must collaborate and build partnerships with community-based organizations, public health departments, and/or social service providers to implement person-centered SDoH interventions. The MCOs are required to follow up on referrals to services to ensure the member has successfully accessed needed services.

In alignment with Goal 5 which aims to provide supports for whole-person wellness and empower individuals to self-manage their health, Objective 3 (Increase the collection, documentation, and use of enrollee-level SDoH data through screening and appropriate referrals), the BMS has contractually required MCOs to adopt a more robust approach to collecting and analyzing SDoH data. The MCOs are required to perform data analytics to identify members' disparities and report on the effectiveness of evidence-based interventions. The MCOs assessment data for aggregate use in population health management, network adequacy determination, and quality improvement activities. In addition, the MCOs encourage contracted providers to use ICD-10 Z-codes on provider claims.

6.3.6 Value-Added Services (VAS).

Each MCO offers an array of VAS in addition to Medicaid covered benefits and services. These "extra" services incentivize members to engage in their health care, including 24-hour help lines, support services for pregnant women, asthma education services, educational programs and equipment for members with diabetes, and incentives for wellness visits, dental care, smoking cessation, mammograms, and certain age-specific vaccines. The MCOs have targeted many of the VAS on the priority health conditions identified in the goals of the Managed Care Quality Strategy.

6.3.7 Disease Management Programs.

All MCOs operate disease management programs to help members with diabetes, asthma, and other chronic conditions live healthier lives. The programs incorporate self-management education, member outreach, case management, and clinical support services. The programs engage patients in their care and promote effective care coordination. The programs align with Goal 2: reduce burden of chronic disease**.**

Section 7: Conclusion

Access to high-quality health care is an essential element in fostering healthy and prosperous communities and families.[38] The BMS is committed to a strong quality and performance improvement approach that ensures managed care programs will continue to deliver quality, accessible care to members, while simultaneously driving improvement in key areas. The quality measures selected for this strategy, paired with comprehensive managed care program reporting, monitoring, and evaluation, will support the BMS in achieving its goals. Delivering high quality care is a continual and dynamic process. The BMS will work closely with the MCOs to continually monitor and assess performance in key priority areas outlined in Section 3. This continuous evaluation will allow the BMS to identify areas for improvement and provide a roadmap for the development and implementation of future programs and interventions. The BMS will continually work to evolve its Managed Care Quality Strategy based on the results of its monitoring, assessment, and improvement activities to ensure it effectively drives improvement in the areas integral to the managed care programs.

[38] *Hurdles to health*. (2023). West Virginia Executive Magazine. Retrieved on: https://wvexecutive.com/hurdles-to-health/

Appendices

Appendix A: Quality Strategy Crosswalk

To ensure compliance with 42 CFR §438.340 and additional federal regulatory requirements in the 2021 CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit, *Table 8* provides a crosswalk of each required element to the corresponding sections in this Managed Care Quality Strategy where the element is located.

Table 8: Quality Strategy Crosswalk

42 CFR § 438.340 - Managed Care State Quality Strategy Requirements			
Required State Elements	**Criteria/Description**	**Regulatory References**	**Managed Care Quality Strategy Section No.**
Section A: General Rule			
(a) General Rule	Each State contracting with an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) as defined in § 438.2 or with a primary care case management (PCCM) entity as described in § 438.310(c)(2) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP or PCCM entity.	§ 438.2 § 438.310	N/A
Section B: Elements of the State Quality Strategy **At a minimum, the State's quality strategy must include the following:**			
(1) Network Adequacy and Provider Access Information	The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by § 438.68 and § 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with § 438.236.	§ 438.68	5.1.2
(2) Continuous Quality Improvement	The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, PAHP, and PCCM entity described in § 438.310(c)(2).	§ 438.310(c)(2)	Section 3
(3) Performance Improvement: Quality Metrics and Performance Targets	The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in § 438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with § 438.330(c).	§ 438.330(c)	6.1.1 and Appendix B
(4) EQR	(4)The State's arrangements for annual EQR of the quality outcomes and timeliness of, and access to, the services covered under each managed care plan.	§ 438.350	4.3
(5) Transition of Care Policy	A description of the State's transition of care policy required under § 438.62(b)(3). Continued services to enrollees: The State must make its transition of care policy publicly available and provide instructions to enrollees	§ 438.62(b)(3)	5.1.5

42 CFR § 438.340 - Managed Care State Quality Strategy Requirements			
Required State Elements	**Criteria/Description**	**Regulatory References**	**Managed Care Quality Strategy Section No.**
	and potential enrollees on how to access continued services upon transition.		
(6) Reduction of Health Disparities	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.	§ 438.340(b)(6)	4.1.1, 4.1.3
(7) Intermediate Sanctions	For the MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	§ 438.700 - 730	5.4
(8) Identification of LTSS	The mechanisms implemented by the State to comply with § 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).	§ 438.208(c)(1)	N/A
(9) Non-duplication of EQR Activities	The information required under § § 438.360(c) (relating to non-duplication of EQR activities).The State must identify in its quality strategy under § 438.340 the EQR activities for which it has exercised the option described in this section, and explain the rationale for the State's determination that the Medicare review or private accreditation activity is comparable to such EQR activities.	§ 438.360(c)	4.3.1
(10) Definition of "Significant Change"	The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section. A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	§ 438.340(c)(3)(ii)	2.1
Section C: Development, Evaluation and Revision **In drafting and revising its quality strategy, the State must:**			
(1) Public Comment	(1) Make the strategy available for public comment before submitting the strategy to the CMS for review, including: (i) Obtaining input from the Medical Services Fund Advisory Council (established by § 431.12 of this chapter), beneficiaries, and other stakeholders. (ii) If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in § 438.340(c)(2), consulting with Tribes in accordance with the State's Tribal consultation policy.	§ 438.340(c)(1)	2.1.2
(2) Review and Update	(2) Review and update the quality strategy as needed, but no less than once every 3 years. (i) This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.	§ 438.340(c)(2)	EQRO ATR
(3) Submission to the CMS	The State must submit to the CMS the following:	§ 438.10(c)(1) § 438.340	Section 2

42 CFR § 438.340 - Managed Care State Quality Strategy Requirements			
Required State Elements	**Criteria/Description**	**Regulatory References**	**Managed Care Quality Strategy Section No.**
	(i) A copy of the initial strategy for the CMS comment and feedback prior to adopting it in final. (ii) A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	(b)(11)	
Section D: Availability			
(d) Availability	The State must make the final quality strategy available on the website required under § 438.10(c)(3). The State must operate a website that provides the content, either directly or by linking to individual MCO, PIHP, PAHP, or PCCM entity websites, specified in paragraphs (g), (h), and (i) of this section.	§ 438.10(c)(3)	Section 2

Appendix B: Quality Measures Tracking Tool

In collaboration with stakeholders, the OQM developed ***Error! Reference source not found.*** to track the progress of achieving the goals outlined in the Managed Care Quality Strategy. The table lists the goals, objectives, and associated quality measures that will be used to measure performance over the next three years. The BMS reviews the performance target data annually to determine what additional quality efforts should be implemented to meet the intended goals of the quality strategy. The BMS updates the tracking tool at least triennially to ensure incremental improvement is made and performance benchmarks align with the NCQA Quality Compass national benchmarks. The BMS strives to meet the NCQA Quality Compass national average (50th percentile) or exceed (66.67th or 90th percentile) where possible. The BMS recognizes that quality measures evolve over time to better align with health data standards and support new models of care delivery, and may, therefore, be updated to ensure the best quality measurement system is available.[39] In the event the performance measures selected for this quality strategy are updated, retired, or replaced, the BMS will make updates to the tracking tool accordingly.

Table 9: Quality Measures Tracking Tool

Objective	Quality Measures Name and Abbreviations*	Baseline**	Performance Target Year 3***
Goal 1: Improve the health and wellness of the State's Medicaid and CHIP populations through use of preventive services.			
Objective 1: Increase number of enrollees receiving preventive care to meet or exceed the NCQA Quality Compass National Average.			
1.1.1	Breast Cancer Screening (BCS-E)	NBD	TBD
1.1.2	Immunizations for Adolescents – Combination 2 (IMA)	25.26	29.44
1.1.3	Lead Screening in Children (LSC)	53.80	59.36
1.1.4	Cervical Cancer Screening (CCS)	50.75	55.92
1.1.5	Colorectal Cancer Screening (COL)	30.28	NBD
Objective 2: Increase number of enrollees attending well and preventive-visits to meet or exceed the NCQA Quality Compass National Average.			
1.2.1	Child and Adolescent Well-Care Visits (WCV) (Total 3-21 Years)	50.34	48.61
1.2.2	Child and Adolescent Well-Care Visits (WCV) (Total 12-17 Years)	49.70	49.94
1.2.3	Child and Adolescent Well-Care Visits (WCV) (Total 18-21 Years)	23.58	25.99
1.2.4	Well-Child Visits in the First 30 Months of Life (WCV) (0-15 Months)	51.86	56.76
1.2.5	Well-Child Visits in the First 30 Months of Life (W30) (15-30) Months	72.14	66.74
1.2.6	Oral Evaluation, Dental Services (OED) (Ages <1 through 20)	TBD	TBD
1.2.7	Topical Fluoride for Children: Ages 1 through 4 (TFC)	TBD	TBD
Objective 3: Increase usage of timely maternal and child health services.			
1.3.1	Prenatal Immunization Status – Combo (PRS-E)	12.77	21.66
1.3.2	Prenatal and Postpartum Care – Postpartum Care (PPC)	78.84	76.96
1.3.3	Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC)	87.16	82.95

[39] NCQA Retiring and Replacing HEDIS Measures 2024-2026. Retrieved from https://www.ncqa.org/blog/retiring-and-replacing-hedis-measures-2024-2026/

Objective	Quality Measures Name and Abbreviations*	Baseline**	Performance Target Year 3***
1.3.4	Live Births Weighing Less Than 2,500 Grams *Lower Rate is Better* (LBW-CH)	11.70 (MY2021)	TBD
1.3.5	Low-Risk Cesarean Delivery *Lower Rate is Better* (LRCD-CH)	25.80 (MY2021)	TBD
Goal 2: Reduce the burden of chronic disease.			
Objective 1: Increase the number of enrollees receiving treatment for respiratory conditions to meet or exceed the NCQA Quality Compass National Medicaid Average.			
2.1.1	Appropriate Testing for Children with Pharyngitis	70.57	77.56 (66.67th percentile)
2.1.2	Appropriate Treatment for Upper Respiratory Infection (URI) (3 months to 17 years of age)[40]	86.45	92.6
2.1.3	Appropriate Treatment for Upper Respiratory Infection (URI) (18 to 64 years of age)[41]	70.68	81.09
2.1.4	Appropriate Treatment for Upper Respiratory Infection (URI) (Total)[42]	82.02	89.85
Objective 2: Increase the number of enrollees receiving diabetes care to meet or exceed the NCQA Quality Compass National Medicaid Average.			
2.2.1	Eye Exam for Patients with Diabetes (EED)	38.15	51.47
2.2.2	Glycemic Status Assessment for Patients with Diabetes (GSD)	NBD	TBD
2.2.3	Kidney Health Evaluation for Patients with Diabetes (KED)	28.06	34.54
Objective 3: Increase the number of enrollees receiving treatment for hypertension to meet or exceed the NCQA Quality Compass National Medicaid Average.			
2.3.1	Controlling High Blood Pressure (CBP)	64.08	65.45 (66.67th percentile)
Goal 3: Improve behavioral health outcomes.			
Objective 1: Increase the number of enrollees receiving follow-up care after behavioral health treatment to meet or exceed the NCQA Quality Compass National Medicaid Average.			
3.1.1	Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase (ADD)	51.24	54.25 (90th percentile)
3.1.2	Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase (ADD)	55.93	57.90 (66.67th percentile)
3.1.3	Antidepressant Medication Management – Effective Acute Phase Treatment (AMM)	71.63	74.16 (90th percentile)
3.1.4	Antidepressant Medication Management – Effective Continuation Phase Treatment (AMM)	57.17	58.06 (90th percentile)
3.1.5	Follow-Up After Hospitalization for Mental Illness – 7-Day Follow-Up (FUM) (6 to 17 years of age)	54.25	60.08 (66.67th percentile)
3.1.6	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	65.22	66.94 (66.67th percentile)
Objective 2: Increase the number of enrollees receiving behavioral health care and treatment.			
3.2.1	Screening for Depression and Follow-Up Plan: Age 18+ (CDF-AD)	TBD	TBD
3.2.2	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	TBD	TBD
3.2.3	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	52.51	57.29

[40] The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment.
[41] The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment.
[42] The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment.

Objective	Quality Measures Name and Abbreviations*	Baseline**	Performance Target Year 3***
Goal 4: Reduce burden of SUD.			
Objective 1: Increase the number of enrollees receiving treatment for SUD to meet or exceed the NCQA Quality Compass National Medicaid Average.			
4.1.1	Pharmacotherapy for Opioid Use Disorder (POD)	37.39	40.34 (90th percentile)
Objective 2: Improve coordination of care for enrollees receiving SUD treatment.			
4.2.1	Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up (13-17) (FUA)	44.00	53.19 (90th percentile)
4.2.2	Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up (18+) (FUA)	59.50	Maintain
4.2.3	Risk of Continued Opioid Use ≥ 30 Days	4.08	3.61
4.2.4	Follow-Up After High-Intensity Care for SUD (7 Days Total) (FUI)	39.65	49.55 (90th percentile)
4.2.5	Follow-Up After High-Intensity Care for SUD (30 Days Total) (FUI)	59.90	57.87 (66.67th percentile)
Goal 5: Provide supports for whole-person wellness and empower individuals to self-manage their health.			
Objective 1: Increase the number of enrollees receiving smoking cessation services to meet or exceed the NCQA Quality Compass National Medicaid Average.			
5.1.1	Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Strategies (MSC)	42.78	45.43
5.1.2	Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers and Tobacco Users to Quit (MSC)	71.96	75.00 (66.67th percentile)
5.1.3	Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Medications (MSC)	46.70	51.16
5.1.4	Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID#226 NQF 0028)	TBD	TBD
Objective 2: Increase the number of enrollees receiving weight management counseling to meet or exceed the NCQA Quality Compass National Medicaid Average.			
5.2.1	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition (WCC)	73.75	76.04 (66.67th percentile)
5.2.2	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity (WCC)	71.08	72.51 (66.67th percentile)

*Assume total measure population unless otherwise noted.
**Baseline MY2022 unless otherwise noted.
***National target is 50th percentile unless otherwise noted.

Appendix C: Implementation and Maintenance Sample Plan

As the delivery system continues to evolve, the quality strategy provides a framework for the BMS to promote quality care for managed care members. The strategy's goals and objectives reflect areas of greatest need so that the BMS and the MCOs can focus their efforts. Implementation and monitoring of the strategy builds on use of existing infrastructure to the extent possible. The OQM will spearhead monitoring and review activities. The BMS will integrate the Managed Care Quality Strategy into existing activities, including MCO reporting, EQR activities, and contracting. *Table 10* outlines ongoing activities and dedicated reviews for monitoring the quality strategy.

Table 10: Annual Quality Strategy Related Activities

Activity	Timeline			
	Quarter 1 (Jan. – Mar.)	***Quarter 2 (Apr. – Jun.)***	***Quarter 3 (Jul. – Sep.)***	***Quarter 4 (Oct. – Dec.)***
MCO Reporting	• Quarterly operating reports. • PIP progress reports. • DPP reporting.	• Quarterly operating reports. • HEDIS® data.* • PIP progress reports. • QAPI annual evaluation. • DPP reporting.	• Quarterly operating reports. • Annual PIP reports. • CAHPS® evaluation & action plan. • Adult & Child Core Set Measures. • APM report. • DPP reporting.	• Quarterly operating reports. • PIP progress reports. • Network adequacy. • DPP reporting.
Managed Care Activities	Draft the MCO contracts.			
EQR Activities	• Systems Performance Site Reviews (SPR). • Quarterly and annual 24/7 access to care report. • Quarterly and annual grievance, appeal, denial (GAD) review. • Network adequacy validation (NAV). • PMV.	• Annual Technical Report (ATR). • Quarterly 24/7 access to care review. • Quarterly GAD review. • Encounter data validation (EDV). • NAV. • Performance measure validation (PMV).	• Validate PIP reports. • Annual SPR report. • Quarterly 24/7 access to care report. • EDV. • Quarterly GAD review. • NAV. • PMV.	• Quarterly 24/7 access to care report. • Quarterly GAD review. • NAV. • PMV.
Stakeholder Engagement	Monthly MCO meetings.	• Monthly MCO meetings.	Monthly MCO meetings.	Monthly MCO meetings.

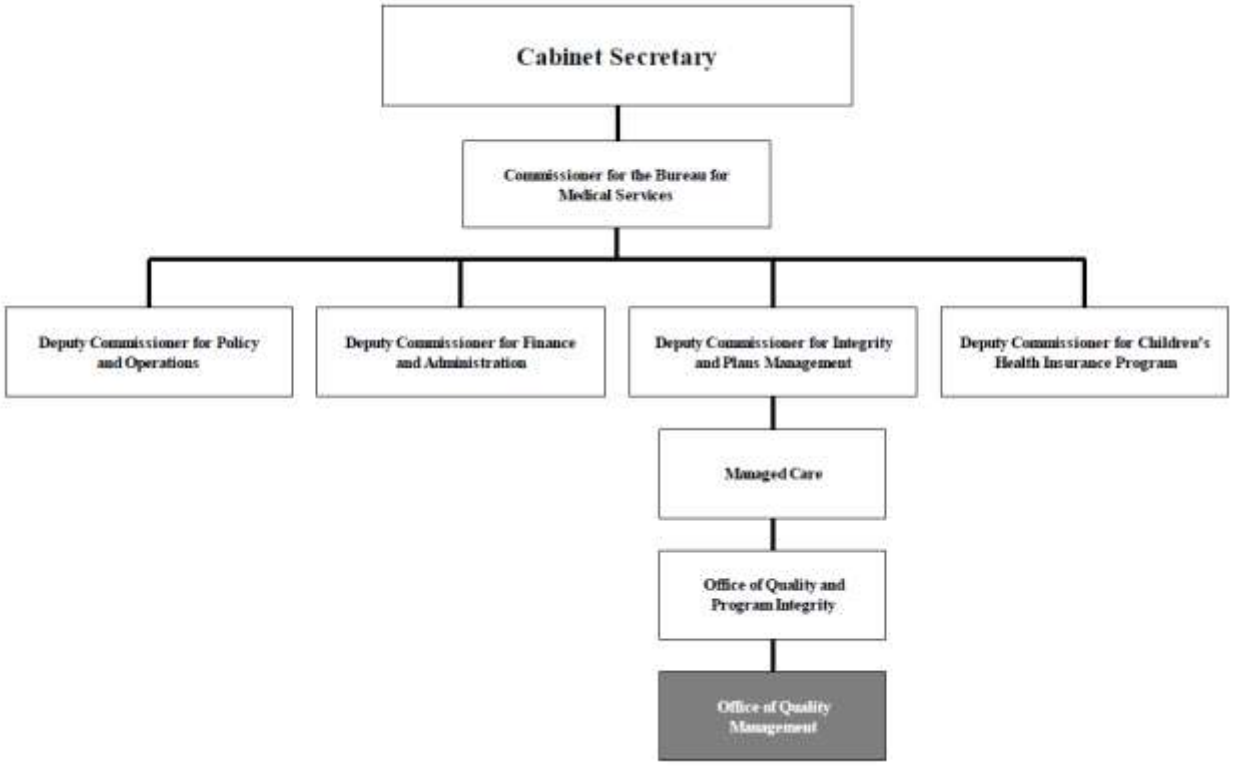
Activity	Timeline			
	Quarter 1 (Jan. – Mar.)	***Quarter 2 (Apr. – Jun.)***	***Quarter 3 (Jul. – Sep.)***	***Quarter 4 (Oct. – Dec.)***
		• Review Managed Care Quality Strategy with additional stakeholder groups identified by the OQM. (year 1 – overview of updated strategy, review progress towards goals/objectives/PMs in years 2 and 3).		

*HEDIS® MY includes data on encounters between January 1 and December 31 of the preceding year (e.g., HEDIS® MY 2023 represents data from December – January 2022).

Appendix D: BMS Organizational Charts

The BMS maintains an organizational structure committed to the implementation and oversight of the managed care programs that serve Medicaid and WVCHIP members. The BMS organizational chart is found in Figure 4.

Figure 4: BMS Organizational Chart



Appendix E: Deemable Elements for Non-duplication

Table 11: Deemable Elements for Non-duplication

Deemable Elements for Non-duplication - NCQA Accredited MCOs	
Information Requirements	
438.10 Information Requirements	(c)(1), (c)(6-7), (d)(1-6)*, (f)(1), f(3), (g)(1-4), (h)(1-4), (i)(1-3)
Access to Care	
438.114 Emergency and Post-Stabilization Services	(b), (c)(1)*, (d)
438.206 Availability of Services	(b)(1-5), (b)(7), (c)(1-3)
438.207 Assurances of Adequate Capacity and Services	(b)
438.208 Coordination and Continuity of Care	(b), (c)(2-4)
438.210 Coverage and Authorization of Services	(a)(3)(ii), (a)(4)(i), (a)(5)*, (b)(2-3), (c-d), (e)*
Structure and Operations	
438.214 Provider Selection	(b), (c)(1), (d)
438.224 Confidentiality	
438.230 Subcontractual Relationships and Delegation	(b), (c)(1), (c)(3)
Quality Measurement and Improvement	
438.236 Practice Guidelines	(b-d)
438.242 Health Information Systems	(a), (b)(2-4)*
438.330 Quality Assessment and Performance Improvement Program	(a)(1), (b)(1-5)*, (c)(1-2)*, (e)(2)
Grievances	
438.402 General Requirements	(a-b), (c)(1)(i)(A), (c)(1)(ii), (c)(2-3)
438.404 Timely and Adequate Notice of Adverse Benefit Determination	(a-c)*
438.406 Handling of Grievances and Appeals	(a-b)
438.408 Resolution and Notification: Grievances and Appeals	(b-c), (d)(2), (e)
438.410 Expedited Resolution of Appeals	(a-c)
438.414 Information about the Grievance System to Providers and Subcontractors	
438.416 Record Keeping Requirements	(a-b)
438.420 Continuation of Benefits While the MCO or PIHP Appeal and the State Fair Hearing are Pending	(a-d)
438.424 Effectuation of Reversed Appeal Resolutions	(a-b)

* NCQA has a requirement but some of the federal requirements are not included in NCQA's accreditation survey and the state or EQRO must conduct review for such elements.

Appendix F: MHT Provider Network Adequacy Standards

This appendix summarizes the network standards and methodology for the MCOs serving MHT enrollees. These standards represent experience in West Virginia and current practices, recent utilization, patterns of care, and take into account provider network standards in use by other state Medicaid and CHIP programs. The intent of setting these standards is to ensure enrollees have adequate access to services.

General Network Requirements

In accordance with 42 CFR §438.68(b), the MCO must establish and maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services available to the populations served in a timely manner. The information provided represents the minimum standards for the MCO's provider network. However, the MCO must ensure access to all services included in the MCO benefits package, even where a standard for the specialty type has not been defined.

As described below, the provider network standards for West Virginia's MCO program include provider-to-enrollee ratios and travel time and distance. The provider-to-enrollee ratios ensure that MCO provider networks have adequate capacity, while the travel time and distance standards establish choice and geographic accessibility of providers. Together, these standards ensure medical services are accessible throughout the State.

In order to meet access requirements, the MCO must meet the defined provider-to-enrollee ratios and time and distance standards in every county. In calculating provider-to-enrollee ratios, the MCO may only count *unique providers* located within the county. For the time and travel standard, the MCO may count *all provider locations* within the county or within the appropriate travel time from the county border. Network standards are consistent across the counties.

Medical Provider Access Standards

Provider-to-Enrollee Ratios

For all adult and pediatric populations served, the MCO must contract with a sufficient number of active providers in each county to meet the following standards, illustrated in *Table 12*.

Table 12: Provider-to-Enrollee Ratios

Provider Type	Adult Standard	Pediatric Standard
PCP	One **provider** for every **500 enrollees** per county.	One **provider** for every **250 enrollees** per county.
OB/GYN or Certified Nurse Midwife	One **provider** for every **1,000 enrollees** per county.	

Medical Provider Network Time and Travel Distance

The MCO must contract with a sufficient number of active providers accepting new patients to meet the following standards for all adult and pediatric populations. For review purposes, medical providers are grouped into the following categories: PCP, OB/GYNs, frequently-used specialists, other specialists, and hospitals. The requirements for each specialty group are outlined in *Table 13* and *Table 14*.

Table 13: Medical Provider Network Time and Travel Distance

Provider Category	Provider Type	Adult Standard	Pediatric Standard
PCP	PCP	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
OB/GYN	OB/GYN or Certified Nurse Midwife	Two providers within **25 miles** or **30 minutes** travel time.	
Frequently-Used Specialist	Allergy	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Audiology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Cardiology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Dermatology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	General Surgery	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Gastroenterology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Neurology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Occupational Therapy	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Oncology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Ophthalmology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Orthopedics	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Orthopedic Surgeon	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Otolaryngology / Otorhinolaryngology	Two providers within **20 miles** or **30 minutes** travel	Two providers within **20 miles** or **30 minutes** travel

Provider Category	Provider Type	Adult Standard	Pediatric Standard
		time.	time.
	Physical Therapy	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Pulmonology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Physical Medicine and Rehabilitation Specialist	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Speech Therapy	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
Other Specialist	Anesthesiology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Chiropractic	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Dialysis	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Durable Medical Equipment (DME)	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Endocrinology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Hematology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Home Health Services	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Nephrology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Neurosurgery	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Orthotics and Prosthetics	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Pathology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Plastic Surgery	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Podiatry	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Radiology	One provider within **20**	One provider within **20**

Provider Category	Provider Type	Adult Standard	Pediatric Standard
		miles or **30 minutes** travel time.	**miles** or **30 minutes** travel time.
	Thoracic Surgery	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Urology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
Hospital	Basic Hospital Services	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.
	Tertiary Hospital Services[43]	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.

[43] Tertiary hospital services include (1) acute care services to pediatric patients in medical and surgical units; (2) obstetrics services; and (3) a neo-natal intensive care unit.

Table 14: Hospitals with Tertiary Services

Hospital Name	Pediatric Medical/ Surgical Unit	Obstetrics Unit	Neonatal Intensive Care Unit
Beckley ARH	YES	NO	NO
CAMC – General Division	YES	YES	NO
CAMC – Memorial Division	YES	NO	NO
CAMC – Teays Valley (Putnam)	YES	YES	NO
CAMC – Women & Children's	YES	YES	YES
Cabell Huntington	YES	YES	YES
Camden-Clark Memorial	YES	YES	NO
Davis Memorial	YES	YES	NO
Grant Memorial	NO	YES	NO
Greenbrier Valley	YES	YES	NO
Jackson General	YES	NO	NO
Logan Regional	YES	YES	NO
Mon Health Medical Center	YES	YES	NO
Mon Health Preston Memorial Hospital	NO	YES	NO
Plateau Medical Center	YES	NO	NO
Princeton Community	YES	YES	NO
Raleigh General	YES	YES	NO
Reynolds Memorial	YES	YES	NO
Rivers Health	YES	YES	NO
Roane General Hospital	YES	NO	NO
Saint Francis Hospital	YES	NO	NO
St Joseph's Buckhannon	YES	YES	NO
St Mary's Medical Center	YES	YES	NO
Stonewall Jackson	NO	YES	NO
Summersville Memorial	YES	YES	NO
Thomas Memorial	YES	YES	YES
Webster County	YES	NO	NO
Weirton Medical Center	YES	YES	NO
Welch Community	NO	YES	NO
Wetzel County	NO	YES	NO
Wheeling Hospital	YES	YES	NO
WVU Hospitals	YES	YES	YES
WVU Medicine Berkeley Medical Center	YES	YES	NO
WVU Medicine Jefferson Medical Center	YES	YES	NO
WVU Medicine United Hospital Center	YES	YES	NO

Pediatric and Adult Dental Network Access Standards

The MCO must contract with a sufficient number of active dental providers accepting new patients and meet the following standards for all pediatric populations. For review purposes, dental providers are grouped as dentists or dental specialists. The requirements for each specialty group are outlined in *Table 15*.

Table 15: Pediatric and Adult Dental Network Standards

Provider Category	Provider Type	Standard
General Dentist	Dentist	Two providers within **25 miles** or **30 minutes** travel time.
Dental Specialist	Oral Surgeon	One provider within **45 miles** or **60 minutes** travel time.
	Orthodontist	One provider within **45 miles** or **60 minutes** travel time.

Behavioral Health Network Access Standards

The MCO must contract with a sufficient number of active behavioral health and SUD providers accepting new patients and meet the following standards for all adult and pediatric populations. For review purposes, behavioral health providers are grouped as behavioral health providers, behavioral health facilities, SUD providers, or SUD facilities. The MCOs are required to contract with all of the DFMB sites. The requirements for each specialty group are outlined in *Table 16*.

Table 16: Behavioral Health Network Access Standards

Provider Category	Provider Type	Adult Standard	Pediatric Standard
BH Provider	Psychologist	Two providers within **45 miles** or **60 minutes** travel time.	Two providers within **45 miles** or **60 minutes** travel time.
	Psychiatrist	Two providers within **45 miles** or **60 minutes** travel time.	Two providers within **45 miles** or **60 minutes** travel time.
	Licensed Professional Counselor (LPC)	Two providers within **45 miles** or **60 minutes** travel time.	Two providers within **45 miles** or **60 minutes** travel time.
	Licensed Independent Clinical Social Worker (LICSW)	Two providers within **45 miles** or **60 minutes** travel time.	Two providers within **45 miles** or **60 minutes** travel time.

Provider Category	Provider Type	Adult Standard	Pediatric Standard
BH Facility	Adult Inpatient Psychiatric Unit	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.	N/A
	Behavioral Health Clinic	Contract with identified list: • Appalachian Community Health Center. • EastRidge Health Systems, Inc. • FMRS Health Systems, Inc. • Healthways, Inc. • Logan-Mingo Area Mental Health, Inc. • Northwood Health Systems, Inc. • Potomac Highlands Mental Health Guild, Inc. • Prestera Center for Mental Health Services. • Seneca Health Services, Inc. • Southern Highlands. • United Summit Center, Inc. • Valley Comprehensive Community Mental Health Center, Inc. • Westbrook Health Services, Inc.	Contract with identified list: • Appalachian Community Health Center. • EastRidge Health Systems, Inc. • FMRS Health Systems, Inc. • Healthways, Inc. • Logan-Mingo Area Mental Health, Inc. • Northwood Health Systems, Inc. • Potomac Highlands Mental Health Guild, Inc. • Prestera Center for Mental Health Services. • Seneca Health Services, Inc. • Southern Highlands. • United Summit Center, Inc. • Valley Comprehensive Community Mental Health Center, Inc. • Westbrook Health Services, Inc.
	PRTF	N/A	Contract with identified list: • Highland Charleston. • River Park. • Barboursville's School.
SUD Provider	Outpatient SUD provider	One provider within **45 miles** or **60 minutes** travel time.	One provider within **45 miles** or **60 minutes** travel time.

Provider Category	Provider Type	Adult Standard	Pediatric Standard
SUD Facility	Residential SUD provider	One provider within **45 miles** or **60 minutes** travel time.	One provider within **45 miles** or **60 minutes** travel time.

Essential Community Providers (ECPs)

The ECPs are types of providers and settings that serve predominantly low-income and medically underserved populations such as FQHCs and RHCs. The MCO must contract with as many FQHCs and RHCs as necessary to permit beneficiary access to participating FQHCs and RHCs without having to travel a significantly greater distance past a non-participating FQHC or RHC. The requirements for FQHCs and RHCs are outlined in *Table 17*.

Table 17: FQHC or RHC Standards

Provider Type	Adult Standard	Pediatric Standard
FQHC or RHC	One provider within **45 miles** or **60 minutes** travel time.	One provider within **45 miles** or **60 minutes** travel time.

Network Adequacy for Additional Provider Types

The BMS may identify additional providers when it promotes the objectives of the Medicaid program as determined by the CMS. The MCO must contract with a sufficient number of these providers who are accepting new patients and must meet the following standards for all adult and pediatric populations. The requirements for additional providers are outlined in *Table 18*.

Table 18: Network Adequacy for Additional Provider Types

Provider Type	Adult Standard	Pediatric Standard
Additional Provider Type to promote the objectives of the Medicaid program as determined by the CMS	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.

Network Submission and Network Adequacy Evaluation

In accordance with the preceding standards, the MCOs must submit to the BMS the provider network information as follows.

Provider Network Submission

Submission of Geographic Data Maps

The MCO must provide individual geographic maps for all medical, dental, and behavioral health provider types and subtypes defined in the preceding standards. Each map must either clearly demonstrate which providers are accepting new patients or only include providers that are accepting new patients.

The MCO must submit supporting data tables with each map. The supporting data tables must include, at a minimum, the name of county, number of eligible enrollees in the county, provider type, number of providers of that type in the county, number of enrollees with access to the

provider type, number of enrollees without access to provider type, percentage of enrollees with access to the provider type, percentage of enrollees without access to provider type, and average distance to available providers.

The geographic data maps and supporting Excel tables by county, for each provider type for which there is a defined time or distance standard must be submitted to the BMS annually.

Submission of Provider Network File

The MCO must submit to the BMS annually by October 31, an Excel file listing all providers and facilities in the MCO's network. Prior to submission, the BMS will provide an Excel file template for the requested data. The files must contain the following information for ***all*** providers and facilities contracting with the MCO:

- Provider names listed in separate columns for last name, first name, middle initial, and degree.
- Provider specialty.
- Provider office names.
- Provider type (e.g., physician, physician assistant (PA), nurse midwife, therapist, FQHC, psychologist, dentist).
- Provider addresses, including the county in which the provider office is located (list all provider locations, including out-of-state).
- Indicator for providers that are not accepting new patients.
- Other provider restrictions, listed in separate columns by type of restriction (i.e., age restrictions, gender restrictions, or any other restrictions).
- Indicator for whether the physician acts as a PCP for physicians with primary care specialties (e.g., family practice, general practice, internal medicine, internal medicine, pediatrics).
- National provider identifier (NPI) and tax ID number, if available.

The MCO may submit separate files for medical, dental, behavioral health, if preferred.
Any network changes must be reported quarterly (45 calendar days after end of the quarter) to the BMS by specialty using the same format.

Submission of Ratio Worksheet

The MCO must complete the provider-to-enrollee ratio worksheet for PCPs and OB/GYNs, using the BMS-provided template. The BMS-provided template contains instructions on which fields the MCO must populate. The MCO must submit the ratio worksheet to BMS annually by October 31.

Provider Network Evaluation

The BMS will evaluate the provider-to-enrollee PCP and OB/GYN network adequacy ratios for the MCO in each county in which the MCO operates. In evaluating, the BMS will compare the number of the MCO's *unique providers* located within the county to the number of the MCO's MHT enrollees within the county. The BMS will calculate the number of MHT enrollees using the greater of:

1. The MCO's actual number of MHT enrollees in the county; or
2. The MCO's estimated number of MHT enrollees, based on the total number of all MHT managed care enrollees within the county, multiplied by the MCO's estimated market share as determined by the number of MCOs operating in the county, as shown in *Table 19*.

Table 19: Network Adequacy Ratios

Number of Participating MCOs	Estimated MHT Market Share
One	100%
Two	50%
Three	33%

To review compliance with time and travel distance standards, the BMS will review geographic data maps and supporting tables to verify appropriate enrollee access to all provider types. The BMS defines adequate access as 90 percent of enrollees in each county having access to every provider type within the specified time and travel distance standards.

If any specialty service cannot be provided by a contracted provider, the MCO must demonstrate how it will ensure Medicaid enrollees' access to this specialty (e.g., allowing out-of-network referrals when appropriate). The BMS will evaluate the number and location of contracted specialists and provisions to ensure access where contracted specialists are not available in determining the overall adequacy of the specialist network in a given county.

The BMS or its contractor will assess the network against the BMS network requirements and provide an assessment of network adequacy to the MCO in a timely manner.

Exception Requests

The BMS will consider requests for exceptions to the provider access standards under limited circumstances (e.g., if no appropriate provider types are located within the mileage standards) and may, at its sole discretion, grant exceptions to these standards. Each exception request from the MCO to the BMS must be in writing and supported by information and documentation from the MCO. Exceptions to network requirements will be considered based on the information provided, current patterns of care, and locations where the travel time and distance standards differ significantly from providers in the community, as allowed in West Virginia's 1915(b) Waiver.

Appendix G: MHP Provider Network Adequacy Standards

This appendix summarizes the network standards and methodology for the MCO serving enrollees under the MHP contract. These standards represent experience in West Virginia and current practices, recent utilization, patterns of care, and provider network standards used by other state Medicaid programs. The intent of setting these standards is to ensure members have adequate access to all covered services.

General Network Requirements

In accordance with 42 CFR §438.68(b), the MCO must establish and maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services available to the populations served in a timely manner. The information provided represents the minimum standards for the MCO's provider network; however, the MCO must ensure access to all services included in the MCO benefits package, even where a standard for the specialty type has not been defined.

The provider network standards for West Virginia's MCO program include provider-to-enrollee ratios and travel time and distance. The provider-to-enrollee ratios ensure that MCO provider networks have adequate capacity, while the travel time and distance standards establish choice and geographic accessibility of providers. Together, these standards ensure medical services are accessible throughout the State.

In order to meet access requirements, the MCO must meet the defined provider-to-enrollee ratios and time and distance standards in every county. In calculating provider-to-enrollee ratios, the MCO may only count *unique providers* located within the county. For the time and travel standard, the MCO may count *all provider locations* within the county or within the appropriate travel time from the county border. Travel time and distance standards are measured from the enrollee's residence to the provider's location. Network standards are consistent across the counties.

Medical Provider Access Standards

Provider-to-Enrollee Ratios

For all adult and pediatric populations served, the MCO must contract with a sufficient number of active providers in each county to meet the following standards.

Table 20: Provider-to-Enrollee Ratios

Provider Type	Adult Standard	Pediatric Standard
PCP	One **provider** for every **500 enrollees** per county.	One **provider** for every **250 enrollees** per county.
OB/GYN or Certified Nurse Midwife	One **provider** for every **1,000 enrollees** per county.	

Medical Provider Network Time and Travel Distance

The MCO must contract with a sufficient number of active providers accepting new patients to meet the following standards for all adult and pediatric populations. For review purposes, medical providers are grouped into the following categories: PCP, OB/GYNs, frequently-used specialists, other specialists, and hospitals. The requirements for each specialty group are outlined below.

Table 21: Medical Group Specialty Group Requirements

Provider Category	Provider Type	Adult Standard	Pediatric Standard
PCP	PCP	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
OB/GYN	OB/GYN or Certified Nurse Midwife	Two providers within **25 miles** or **30 minutes** travel time.	
Frequently-Used Specialist	Allergy	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Audiology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Cardiology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Dermatology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	General Surgery	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Gastroenterology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Neurology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Occupational Therapy	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Oncology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Ophthalmology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Orthopedics	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Orthopedic Surgeon	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Otolaryngology/ Otorhinolaryngology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Physical Therapy	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Pulmonology	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Physical Medicine and Rehabilitation Specialist	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
	Speech Therapy	Two providers within **20 miles** or **30 minutes** travel time.	Two providers within **20 miles** or **30 minutes** travel time.
Other Specialist	Anesthesiology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Chiropractic	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Dialysis	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	DME	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Endocrinology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Hematology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Home Health Services	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.

Provider Category	Provider Type	Adult Standard	Pediatric Standard
	Nephrology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Neurosurgery	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Orthotics and Prosthetics	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Pathology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Plastic Surgery	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Podiatry	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Radiology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Thoracic Surgery	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
	Urology	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.
Provider Category	**Provider Type**	**Adult Standard**	**Pediatric Standard**
Hospital	Basic Hospital Services	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.
	Tertiary Hospital Services[44]	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.

[44] Tertiary hospital services include (1) acute care services to pediatric patients in medical and surgical units; (2) obstetrics services; and (3) a neo-natal intensive care unit.

Table 22: Hospitals with Tertiary Services

Hospital Name	Pediatric Medical / Surgical Unit	Obstetrics Unit	Neonatal Intensive Care Unit
Beckley ARH	YES	NO	NO
Bluefield Regional	YES	NO	NO
CAMC - General Division	YES	YES	NO
CAMC - Memorial Division	YES	NO	NO
CAMC - Teays Valley (Putnam)	YES	YES	NO
CAMC - Women & Children's	YES	YES	YES
Cabell Huntington	YES	YES	YES
Camden-Clark Memorial	YES	YES	NO
Davis Memorial	YES	YES	NO
Fairmont General	YES	YES	NO
Grant Memorial	NO	YES	NO
Greenbrier Valley	YES	YES	NO
Jackson General	YES	NO	NO
Logan Regional	YES	YES	NO
Mon Health Medical Center	YES	YES	NO
Mon Health Preston Memorial Hospital	NO	YES	NO
Plateau Medical Center	YES	NO	NO
Princeton Community	YES	YES	NO
Raleigh General	YES	YES	NO
Reynolds Memorial	YES	YES	NO
Rivers Health	YES	YES	NO
Roane General Hospital	YES	NO	NO
Saint Francis Hospital	YES	NO	NO
St Joseph's Buckhannon	YES	YES	NO
St Mary's Medical Center	YES	YES	NO
Stonewall Jackson	NO	YES	NO
Summersville Memorial	YES	YES	NO
Thomas Memorial	YES	YES	YES
Webster County	YES	NO	NO
Weirton Medical Center	YES	YES	NO
Welch Community	NO	YES	NO
Wetzel County	NO	YES	NO
Wheeling Hospital	YES	YES	NO
Williamson Memorial Hospital	YES	NO	NO
WVU Hospitals	YES	YES	YES
WVU Medicine Berkeley Medical Center	YES	YES	NO
WVU Medicine Jefferson Medical Center	YES	YES	NO
WVU Medicine United Hospital Center	YES	YES	NO

Pediatric Dental Network Access Standards

The MCO must contract with a sufficient number of active dental providers accepting new patients and meet the following standards for all pediatric populations. For review purposes, dental providers are grouped as dentists or dental specialists. The requirements for each specialty group are outlined in *Table 23*Table 23: Dental Providers Specialty Groups Requirements.

Table 23: Dental Providers Specialty Groups Requirements

Provider Category	Provider Type	Pediatric Standard
General Dentist	Dentist	Two providers within **25 miles** or **30 minutes** travel time.
Dental Specialist	Oral Surgeon	One provider within **45 miles** or **60 minutes** travel time.
	Orthodontist	One provider within **45 miles** or **60 minutes** travel time.

Behavioral Health Network Access Standards

The MCO must contract with a sufficient number of active behavioral health and SUD providers accepting new patients and meet the following standards for all adult and pediatric populations. For review purposes, behavioral health providers are grouped as behavioral health providers, behavioral health facilities, SUD providers, or SUD facilities. The MCO is required to contract with all of the DFMB sites. The requirements for each specialty group are outlined in Table 24.

Table 24: Behavioral Health and SUD Providers Specialty Group Requirements

Provider Category	Provider Type	Adult Standard	Pediatric Standard
BH Provider	Psychologist	Two providers within **45 miles** or **60 minutes** travel time.	Two providers within **45 miles** or **60 minutes** travel time.
	Psychiatrist	Two providers within **45 miles** or **60 minutes** travel time.	Two providers within **45 miles** or **60 minutes** travel time.
	LPC	Two providers within **45 miles** or **60 minutes** travel time.	Two providers within **45 miles** or **60 minutes** travel time.
	LICSW	Two providers within **45 miles** or **60 minutes** travel time.	Two providers within **45 miles** or **60 minutes** travel time.
BH Facility	Adult Inpatient Psychiatric Unit	**Urban:** One hospital within **30 miles** or **45 minutes** travel time. **Rural:** One hospital within **60 miles** or **90 minutes** travel time.	N/A
	Behavioral Health Clinic Psychiatric Residential Treatment Facility (PRTF)	Contract with identified list: • Appalachian Community Health Center. • EastRidge Health Systems, Inc. • FMRS Health Systems, Inc. • Healthways, Inc. • Logan-Mingo Area Mental Health, Inc.	Contract with identified list: • Appalachian Community Health Center. • EastRidge Health Systems, Inc. • FMRS Health Systems, Inc. • Healthways, Inc. • Logan-Mingo Area Mental Health, Inc.

Provider Category	Provider Type	Adult Standard	Pediatric Standard
		• Northwood Health Systems, Inc. • Potomac Highlands Mental Health Guild, Inc. • Prestera Center for Mental Health Services. • Seneca Health Services, Inc. • Southern Highlands. • United Summit Center, Inc. • Valley Comprehensive Community Mental Health Center, Inc. • Westbrook Health Services, Inc. • Contract with identified list: • Highland Charleston. • River Park. • Barboursville's School.	• Northwood Health Systems, Inc. • Potomac Highlands Mental Health Guild, Inc. • Prestera Center for Mental Health Services • Seneca Health Services, Inc. • Southern Highlands. • United Summit Center, Inc. • Valley Comprehensive Community Mental Health Center, Inc. • Westbrook Health Services, Inc. • Contract with identified list: • Highland Charleston. • River Park. • Barboursville's School.
	PRTF	N/A	Contract with identified list: • Highland Charleston. • River Park. • Barboursville's School.
SUD Provider	Outpatient SUD provider	One provider within **45 miles** or **60 minutes** travel time.	One provider within **45 miles** or **60 minutes** travel time.
SUD Facility	Residential SUD provider	One provider within **45 miles** or **60 minutes** travel time.	One provider within **45 miles** or **60 minutes** travel time.

Essential Community Providers (ECPs)

The ECPs are types of providers and settings that serve predominantly low-income and medically underserved populations such as FQHCs and RHCs. The MCO must contract with as many FQHCs and RHCs as necessary to permit beneficiary access to participating FQHCs and RHCs without having to travel a significantly greater distance past a non-participating FQHC or RHC. The requirements for FQHCs and RHCs are outlined in *Table 25*.

Table 25: FQHC and RHC Requirements

Provider Type	Adult Standard	Pediatric Standard
FQHC or RHC	One provider within **45 miles** or **60 minutes** travel time.	One provider within **45 miles** or **60 minutes** travel time.

Network Adequacy for Additional Providers Types

The Department may identify additional providers when it promotes the objectives of the Medicaid program as determined by the CMS. The MCO must contract with a sufficient number of these providers who are accepting new patients and must meet the following standards for all adult and pediatric populations. The requirements for additional providers are outlined in *Table 26.*

Table 26: Additional Provider Requirements

Provider Type	Adult Standard	Pediatric Standard
Additional Provider Type to promote the objectives of the Medicaid program as determined by CMS	One provider within **20 miles** or **30 minutes** travel time.	One provider within **20 miles** or **30 minutes** travel time.

Network Submission and Network Adequacy Evaluation

In accordance with the preceding standards, the MCOs must submit to the Department the following provider network information as described below.

Provider Network Submission

Submission of Geographic Data Maps

The MCO must provide individual geographic maps for all medical, dental, and behavioral health provider, ECP, and other provider types and subtypes defined in the preceding standards. Each map must either clearly demonstrate which providers are accepting new patients or only include providers accepting new patients.

The MCO must submit supporting data tables with each map. The supporting data tables must include, at a minimum, the name of county, number of eligible enrollees in the county, provider type, number of providers of that type in the county, number of enrollees with access to the provider type, number of enrollees without access to provider type, percentage of enrollees with access to the provider type, percentage of enrollees without access to provider type, and average distance to available providers.

The tables with the supporting data must follow each individual geographic data map. The MCO must provide data for all provider types in both PDF and Excel formats.

The geographic data maps in PDF format and supporting tables in PDF and Excel, by county for each provider type for which there is a defined time or distance standard must be submitted to the Department annually by October 31.

Submission of Provider Network File

The MCO must submit to the Department annually, by October 31 an Excel file listing all providers and facilities in the MCO's network. Prior to submission, the Department will provide an Excel file template for the requested data. The files must contain the following information for ***all*** providers and facilities contracting with the MCO:

1. Provider names listed in separate columns for last name, first name, middle initial, and degree.
2. Provider specialty.
3. Provider office names.
4. Provider type (e.g., physician, physician assistant, nurse midwife, therapist, FQHC, psychologist, dentist).
5. Provider addresses, including the county in which the provider office is located (list all provider locations, including out-of-state).
6. Indicator for providers that are not accepting new patients.
7. Other provider restrictions, listed in separate columns by type of restriction (i.e., age restrictions, gender restrictions, or any other restrictions).
8. Indicator for whether the physician acts as a PCP for physicians with primary care specialties (e.g., family practice, general practice, internal medicine, internal medicine, pediatrics).
9. NPI and tax ID number, if available.

The MCO may submit separate files for medical, dental, behavioral health, if preferred.
Any network changes must be reported quarterly (45 calendar days after end of the quarter) to the Department by specialty, using the same format.

Submission of Ratio Worksheet

The MCO must complete the provider-to-enrollee ratio worksheet for PCPs and OB/GYNs, using the Department-provided template. The Department-provided template contains instructions on which fields the MCO must populate. The MCO must submit the ratio worksheet to the Department annually, by October 31.

Provider Network Evaluation

The Department will evaluate the provider-to-enrollee PCP and OB/GYN network adequacy ratios for the MCO in each county in which the MCO operates. In evaluating, the Department will compare the number of the MCO's unique providers located within the county to the number of the MCO's enrollees within the county.

To review compliance with time and travel distance standards, the Department will review geographic data maps and supporting tables to verify appropriate enrollee access to all provider

types. The BMS defines adequate access as 90 percent of enrollees in each county have access to every provider type within the specified time and travel distance standards.

If any specialty services cannot be provided by a contracted provider, the MCO must demonstrate how it will ensure Medicaid enrollees' access to this specialty (e.g., allowing out-of-network referrals when appropriate). The Department will evaluate the number and location of contracted specialists and provisions to ensure access where contracted specialists are not available in determining the overall adequacy of the specialist network in a given county.

The Department or its contractor will assess the network against the Department's network requirements and provide an assessment of network adequacy to the MCO in a timely manner.

Exception Requests

The Department will consider requests for exceptions to the provider access standards under limited circumstances (e.g., if no appropriate provider types are located within the mileage standards) and may, in its sole discretion, grant exceptions to these standards. Each exception request from the MCO to the Department must be in writing and include detailed information with supporting documentation regarding how they will mitigate the provider network deficit and meet the needs of the enrollees. Exceptions to network requirements will be considered based on the information provided, current patterns of care, and locations where the travel time and distance standards differ significantly from providers in the community.

Appendix H: Acronyms

Acronym	Term
ATR	Annual Technical Report
BBH	Bureau for Behavioral Health
BCF	Bureau for Children and Families
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCBHC	Certified Community Behavioral Health Center
CDC	Center for Disease Control and Prevention
CHIP	Children's Health Insurance Program
COPD	Chronic Obstructive Pulmonary Disease
CMS	Center for Medicare & Medicaid Services
CSED	Children with Serious Emotional Disorders
CSEDW	Children with Serious Emotional Disorders Waiver
CY	Calendar Year
DFMB	Drug Free Moms and Babies
DEA	Drug Enforcement Administration
DoHS	Department of Human Services
DOJ	Department of Justice
DPP	Directed Payment Program
DSS	Decision Support System
DW	Data Warehouse
ECP	Essential Community Provider
EDS	Enterprise Data Solutions
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
HCBS	Home- and Community-Based Services
HEDIS®	Healthcare Effectiveness Data and Information Set
MCI	Mobile Crisis Intervention
MCO	Managed Care Organization
MHP	Mountain Health Promise
MHT	Mountain Health Trust
MIS	Office of Management Information Services
MMIS	Medicaid Management Information Services
MSFAC	Medical Services Fund Advisory Council
MY	Measurement Year
NCQA	National Committee for Quality Assurance
OB-GYN	Obstetrics and Gynecology
OSA	Office of Shared Administration, West Virginia Departments of Health, Health Facilities, and Human Services
OQM	Office of Quality Management

Acronym	Term
PA	Physician Assistant
PAHP	Prepaid inpatient health plan
PCP	Primary Care Provider
PIHP	Prepaid inpatient health plan
PIP	Performance Improvement Project
PM	Performance Measure
QAPI	Quality Assurance and Performance Improvement
QIA	Quality Improvement Advisory (Council)
RAPIDS	Recipient Automated Payment and Information Data System
RHC	Rural Health Clinic
SAMSHA	Substance Abuse and Mental Health Services Administration
SDoH	Social Determinants of Health
SFY	State Fiscal Year
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
QAPI	Quality Assessment and Performance Improvement
QS	Quality Strategy
WVCHIP	West Virginia Children's Health Insurance Program