West Virginia Department of Health and Human Resources

Bureau for Medical Services

Managed Care Programs

Mountain Health Trust

Mountain Health Promise

Qlarant

2021 External Quality Review

Annual Technical Report

April 2022

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West Virginia Managed Care Programs

2021 Annual Technical Report

Executive Summary

Introduction

The West Virginia (WV) Department of Health and Human Resources' Bureau for Medical Services (BMS) contracts with Qlarant, an external quality review organization (EQRO), to evaluate WV's managed care programs: Mountain Health Trust (MHT) and Mountain Health Promise (MHP). The MHT program provides physical and behavioral health services and has served Medicaid beneficiaries since 1996 and Children's Health Insurance Program (CHIP) beneficiaries since January 1, 2021. Managed care plans (MCPs) contracted to provide MHT services include:

- Aetna Better Health of West Virginia (ABHWV)
- The Health Plan of West Virginia (THP)
- UniCare Health Plan of West Virginia (UHP)

The MHP program serves Medicaid beneficiaries who are in foster care or receive adoption services and qualifying children with serious emotional disorders. The program provides comprehensive physical and behavioral health services, children's residential care services, and socially necessary services administration. ABHWV is contracted to provide these services. Operations for this program commenced on March 1, 2020.

As the WV EQRO, Qlarant evaluates MCP compliance with federal and state-specific requirements by conducting multiple external quality review (EQR) activities including:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review also known as Systems Performance Review (SPR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Grievance, Appeal, and Denial (GAD) Focused Study

Qlarant conducted EQR activities throughout 2021 and evaluated MCP compliance and performance for measurement years (MYs) 2020 and 2021, as applicable. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities.[1] This report summarizes results from all EQR activities and includes conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs.

[1] CMS EQRO Protocols

Key Findings

Key findings are summarized below for the MHT MCPs and MHP ABHWV, where applicable. MCP-specific strengths, weaknesses, and recommendations are identified within the MCP Quality, Access, Timeliness Assessment section of the report. MCP findings correspond to performance related to the quality, accessibility, and timeliness of services provided to their members.

Performance Improvement Project Validation. The MCPs conducted three PIPs each and reported results, as applicable, for MY 2020. The MHT MCPs were challenged with COVID-19 public health emergency barriers in the state-mandated Annual Dental Visits PIP and received validation scores ranging from 81%-95%. All MHT MCPs demonstrated statistically significant improvement in the State mandated Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP and received scores ranging from 96%-99%. Each MCP's third PIP topic was self-selected and MCPs are at various stages of development with their projects. Scores ranged from 85%-100%. MHP ABHWV submitted proposal PIPs for its two state-mandated projects, Annual Dental Visits and Care for Adolescents and a baseline PIP for its self-selected topic, Reducing Out-of-State Placements for Children in Foster Care. MHP ABHWV's PIP submissions received validation scores ranging from 98%-100%.

Performance Measure Validation. Information Systems Capability Assessments determined all MHT and MHP MCPs had appropriate systems in place to process accurate claims and encounters. All MCPs received a rating of 100%. MY 2020 performance measure results were assessed as "reportable."

Systems Performance Review. Qlarant evaluated MY 2020 MHT and MHP MCP compliance with the following Code of Federal Regulations standards: MCO Standards and Program Integrity Requirements Under the Contract. MHT MCP scores ranged from 96%-100%. THP and UHP were required to develop and implement corrective action plans (CAPs) to address noncompliant elements and components of the standards, which related to Availability of Services, Assurance of Adequate Capacity and Services, and Coordination and Continuity of Care. The MCPs successfully implemented all CAPs and demonstrated compliance. MHP ABHWV scored 100% in the standards reviewed.

Network Adequacy Validation. Surveyors, assessing MY 2021 24/7 access to care, were successful in contacting provider offices after regular business hours 83%-91% of the time for the MHT MCPs. The successful contact rate for MHP ABHWV was lower, 76%. Unsuccessful contact was most frequently due to the phone number not reaching the intended provider. For successful provider contacts, MHT MCPs demonstrated compliance with directing members to care the majority of the time. MHT MCP compliance ranged from 94%-100%. MHP ABHWV was compliant 95% of the time.

Encounter Data Validation. All MCPs provided evidence of having the capability to produce accurate and complete encounter data. For claims paid during MY 2020, analysts found MCP claims volume was reasonable, most claims were submitted timely, data was complete and included valid values, and diagnoses and procedure codes were appropriate based on member demographics. A medical record review concluded documentation supported encounter data. All MHT MCPs had a 96% encounter data accuracy rating. MHP ABHWV's accuracy rating was 97%.

Grievance, Appeal, and Denial Focused Study. An assessment of MY 2020 MHT grievances, denials, and appeals concluded MCPs complied with requirements, including timely acknowledgment and resolution notices and required documentation, as applicable, in most instances. MHT MCP compliance ratings ranged from: 87%-100% for grievances, 98%-99% for denials, and 95%-100% for appeals. MHP ABHWV's

compliance ratings included: 67% for grievances and 100% for both denials and appeals. Caution is advised when interpreting ABHWV's grievance compliance rate, as the MCP only received five grievances for the year and process deficiencies identified during quarter 1 2020 were immediately corrected.

Conclusion

WV's MCPs are National Committee for Quality Assurance (NCQA) accredited, demonstrating their commitment to quality improvement.[2] The MCPs are largely compliant with federal and state managed care requirements. When deficiencies are identified, the MCPs respond quickly with corrective actions. The MCPs demonstrated an improvement in the quality and effectiveness of interventions in their PIPs. The MCPs, based on weighted averages, performed better than national average benchmarks in 69% of HEDIS measures and 54% of CAHPS survey measures, as reported in Appendix A1 and A2. MCP performance continues to trend in a positive direction and provides evidence of improved quality, accessibility, and timeliness of health care. The State should continue to monitor performance and adjust goals to encourage the positive trend in performance.

[2] The WV MCP accreditation is based on an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). HEDIS® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

West Virginia Managed Care Programs

2021 Annual Technical Report

Introduction

Background

The West Virginia (WV) Department of Health and Human Resources' (DHHR) Bureau for Medical Services (BMS) administers the state's two managed care programs: Mountain Health Trust (MHT) and Mountain Health Promise (MHP). These programs coordinate care and services for qualifying West Virginians meeting specific income or vulnerable population requirements and are described below.

MHT.[3] This managed care program, operating under a 1915(b) waiver, provides physical and behavioral health services to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. The MHT program has provided Medicaid services since 1996 and CHIP services were added on January 1, 2021. The program emphasizes effective organization, financing, and delivery of health care services and aims to improve quality and access to coordinated services for qualifying beneficiaries through three managed care plans (MCPs). These plans, serving more than 477,000 members, include:[4]

- Aetna Better Health of West Virginia (ABHWV)
- The Health Plan of West Virginia (THP)
- UniCare Health Plan of West Virginia (UHP)

MHP.[5] This specialized managed care program provides comprehensive physical and behavioral health services, children's residential care services, and socially necessary services administration to select Medicaid managed care beneficiaries who are in foster care or receive adoption service, and children eligible for serious emotional disorder home and community based services. The program, effective March 1, 2020, is operating under 1915(b) and 1915(c) waivers. MHP aims to reduce fragmentation and deliver supports and services in a seamless, integrated, and cost-effective manner. ABHWV is the sole MCP providing these services to approximately 27,000 members.[6]

BMS provides oversight of the Medicaid managed care populations, while WVCHIP is responsible for the CHIP population. BMS and WVCHIP collaboratively strive to ensure the delivery of high quality, accessible care for managed care program members. As outlined in the *West Virginia Managed Care Quality Strategy*, managed care program goals include:

Goal 1. Promoting a health care delivery system that consistently offers: timely access to health care; high clinical quality, including use of evidence-based models of treatment; care at the appropriate time to deter avoidable use of emergency and acute care; and children and adolescents' access to primary care according to the periodicity schedule.

[3] Mountain Health Trust
[4] *West Virginia Medicaid Managed Care and Fee for Service Monthly Report 2021* – December 2021 statistics for MHT Managed Care
[5] Mountain Health Promise
[6] *West Virginia Medicaid Managed Care and Fee for Service Monthly Report 2021* – December 2021 statistics for MHP Managed Care

Goal 2. Offering tools and supports that empower individuals to self-manage their health, whole-person and whole-household wellness and use of health care services.
Goal 3. Promoting effective communication and team-based care to better coordinate care across the full continuum of health care.
Goal 4. Reducing the incidence of targeted conditions that negatively impact health and quality of life.
Goal 5. Strengthening State oversight of programs to maximize partnership with contracted MCPs as committed partners to driving health impacts and acting as good stewards of resources.

The State uses a three-pronged approach to meet goals including:

Monitoring. BMS and WVCHIP monitor MCP compliance with managed care quality standards.
Assessment. BMS and WVCHIP analyze a variety of health care data to measure performance and identify areas for improvement.
Improvement. BMS, WVCHIP, and MCPs implement interventions targeting priority areas to maximize the benefit to managed care program members.

The State requires MCPs to attain and maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA evaluates the quality of health care plans provided to its members. Accreditation signifies a plan's commitment to quality improvement. The West Virginia MCP accreditation is based on an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).[7, 8]

Table 1 provides MCP NCQA accreditation status and other descriptive information.[9]

Table 1. MCP Accreditation Status

MCP	NCQA Health Plan Accreditation	NCQA Distinction	Next Review Date
ABHWV	Accredited	Electronic Clinical Data	7/12/22
THP	Accredited	None	5/31/22
UHP	Accredited	Multicultural Health Care	5/28/24

Applicable NCQA distinctions achieved by one or more MCPs are described below.

Electronic Clinical Data Distinction. This distinction recognizes organizations that have an accepted rate for a non-publicly reported measure that leverages electronic clinical data and was originally introduced for the HEDIS Electronic Clinical Data System Reporting Standard.

Multicultural Health Care Distinction. This program offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires BMS to contract with an external quality review organization (EQRO) to conduct annual, independent reviews of WV's managed care programs.

[7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[8] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[9] https://reportcards.ncqa.org/health-plans, status: January 15, 2022

To meet these requirements, BMS contracts with Qlarant. As the EQRO, Qlarant evaluates each WV MCP's compliance with federal and WV-specific requirements in a manner consistent with the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols. During 2021, Qlarant conducted the following EQR activities:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review also known as Systems Performance Review (SPR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Grievance, Appeal, and Denial (GAD) Focused Study

In addition to completing EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs. This Annual Technical Report (ATR) summarizes Qlarant's EQR findings based on MCP audits conducted during 2021. The report describes objectives, methodologies, results, and conclusions for each EQR activity. Qlarant identifies MCP strengths and weaknesses relating to quality, access, and timeliness of care provided to managed care members. The report also includes recommendations for improvement for the MCPs and the State, which if acted upon, may positively impact member outcomes and experiences.

Performance Improvement Projects

Objective

MCPs conduct PIPs as part of their quality assessment and performance improvement program in accordance with 42 CFR §438.330(d). PIPs use a systematic approach to quality improvement and can be effective tools to assist MCPs in identifying barriers and implementing targeted interventions to achieve and sustain improvement in clinical outcomes or administrative processes. PIP EQR activities verify the MCP used sound methodology in its design, implementation, analysis, and reporting. PIP review and validation assesses the MCP level of improvement and provides the State and other stakeholders a level of confidence in results.

Methodology

BMS required MCPs to report three PIPs during 2021. Two PIPs were state-mandated initiatives and one was MCP selected, which required BMS and EQRO approval.

Description of Data Obtained. MCPs documented measurement year (MY) 2020 PIP-related activities, improvement strategies, and measure results in their 2021 reports. The MCPs submitted their reports, which included one submission per PIP topic, to Qlarant in July 2021 and used validated performance measure results in their submissions. MCPs completed a data and barrier analysis and identified follow-up activities in each PIP submission. MCPs used Qlarant reporting tools and worksheets to report their PIPs. Qlarant provided MCP-specific technical assistance, as requested.

Technical Methods of Data Collection and Analysis. MCPs submitted a narrative report and calculations worksheet for each PIP. Qlarant reviewed PIP submissions to assess the MCP's PIP methodology and to perform an overall validation of PIP results. Qlarant completed these activities in a manner consistent with the *CMS EQR Protocol 1 – Validation of Performance Improvement Projects*.[10] PIP validation includes the following nine steps:

1. **Review the selected PIP topic.** Qlarant determines if the PIP topic targets an opportunity for improvement and is relevant to the MCP's population.
2. **Review the PIP aim statement.** Qlarant evaluates the adequacy of the PIP aim statement, which should frame the project and define the improvement strategy, population, and time period.
3. **Review the identified PIP population.** Qlarant determines whether the MCP identifies the PIP population in relation to the aim statement.
4. **Review the sampling method.** If the MCP studied a sample of the population, rather than the entire population, Qlarant assesses the appropriateness of the MCP's sampling technique.
5. **Review the selected PIP variables and performance measures.** Qlarant assesses whether the selected PIP variables are appropriate for measuring and tracking improvement. Performance measures should be objective and measurable, clearly defined, based on current clinical knowledge or research, and focused on member outcomes.
6. **Review the data collection procedures.** Qlarant evaluates the validity and reliability of MCP procedures used to collect the data informing PIP measurements.
7. **Review data analysis and interpretation of PIP results.** Qlarant assesses the quality of data analysis and interpretation of PIP results. The review determines whether appropriate techniques were used, and if the MCP analysis and interpretation were accurate.
8. **Assess the improvement strategies (interventions).** Qlarant assesses the appropriateness of interventions for achieving improvement. The effectiveness of an improvement strategy is determined by measuring changes in performance according to the PIP's predefined measures. Data should be evaluated on a regular basis, and subsequently, interventions should be adapted based on what is learned.
9. **Assess the likelihood that significant and sustained improvement occurred.** Qlarant evaluates improvement by validating statistical significance testing results and evaluating improvement compared to baseline performance.

Qlarant PIP reviewers evaluated each element of PIP development and reporting by answering a series of applicable questions for each step, consistent with CMS protocol worksheets and requirements. Steps 7-9, critical to PIP success, had the most impact on the validation score. Reviewers sought additional information and/or corrections from MCPs, when needed, during the evaluation. Qlarant determined a validation rating, or level of confidence, for each PIP based on the total validation score.[11] Validation ratings include:

- ❖ 90% - 100%: high confidence in MCP results
- ❖ 75% - 89%: moderate confidence in MCP results
- ❖ 60% - 74%: low confidence in MCP results
- ❖ ≤59%: no confidence in MCP results

[10] CMS EQRO Protocols

[11] Validation rating refers to the overall confidence that a PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement (CMS EQR Protocol 1 – Validation of Performance Improvement Projects).

Results

PIP validation results for 2021 MCP-reported PIPs, including MY 2020 activities and performance measure (PM) rates, are included in this report. Table 2 highlights key elements of the two state-mandated PIPs for the MHT program: (1) Annual Dental Visits and (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence.

Table 2. MHT State Mandated PIPs

2021 PIPs	State Mandated PIP 1	State Mandated PIP 2
Program	MHT	MHT
Topic	Annual Dental Visits	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
Performance Measure(s), Measure Steward, & Population	**PM 1:** Annual Dental Visits for 2-3 Year Olds **Measure steward:** NCQA **Population:** Children 2-3 years of age **PM 2:** Percentage of Eligibles that Received Preventative Dental Services **Measure steward:** CMS **Population:** Children, adolescents, and adults 1-20 years of age	**PM 1:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Day Follow-Up (Total) **Measure steward:** NCQA **Population:** Adolescents and adults 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence
Aim	Will implementation of targeted member/provider/MCP interventions improve rates of annual dental visits for members 2-3 years old and eligibles receiving preventative dental services for members 1-20 years old each measurement year?	Will implementation of targeted member/provider/MCP interventions improve the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (30 Day Follow-Up) rate for members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence each measurement year?
Phase	3rd Remeasurement	1st Remeasurement

Table 3 provides an overview of each MHT MCP selected PIP.

Table 3. MHT MCP Selected PIPs

2021 PIPs	ABHWV	THP	UHP
Program	MHT	MHT	MHT
Topic	Care for Adolescents	Promoting Health and Wellness in Children and Adolescents	Immunizations for Adolescents
Performance Measure(s), Measure Steward, & Population	**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 - • 12-17 Year Olds • 18-21 Year Olds **Measure steward:** NCQA **Population:** Adolescents and adults 12-21 years of age	**PM 1:** Child and Adolescent Well-Care Visits - Total **Measure steward:** NCQA **Population:** Children, adolescents, and adults 3-21 years of age **PM 2 and 3:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – • Body Mass Index (BMI) Percentile Documentation • Counseling for Nutrition **Measure steward:** NCQA **Population:** Children and adolescents 3-17 years of age	**PM 1 and 2:** Immunizations for Adolescents - • Combination 2 • Human Papillomavirus (HPV) **Measure steward:** NCQA **Population:** Adolescents 13 years of age
Aim	Will multipronged interventions improve the rates of adolescent care, including well visits and immunizations received amongst members ages 9-21 enrolled with Aetna Better Health of West Virginia?	Will focus on improving children and adolescents' well-being increase rates for the Child and Adolescent Well Care Visits and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measures by 10 percentage points?	Will implementation of member, provider, and MCP interventions increase rates for Immunizations for Adolescents Combination 2 and HPV over the life of the PIP?
Phase	Baseline	PM 1: Baseline PM 2 & 3: 2nd Remeasurement	Baseline

Table 4 highlights the MHP PIPs, including two state-mandated PIPs and one selected by ABHWV.

Table 4. MHP State and MCP Selected PIPs

2021 PIPs	State Mandated	State Mandated	MCP Selected
Program	MHP	MHP	MHP
Topic	Annual Dental Visits	Care for Adolescents	Reducing Out-of-State Placements for Children in Foster Care
Performance Measure(s), Measure Steward, & Population	**PM 1:** Annual Dental Visits for 2-3 Year Olds **Measure steward:** NCQA **Population:** Children 2-3 years of age **PM 2:** Percentage of Eligibles that Received Preventative Dental Services **Measure steward:** CMS **Population:** Children, adolescents, and adults 1-20 years of age	**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 – 12-17 Year Olds and 18-21 Year Olds **Measure steward:** NCQA **Population:** Adolescents and adults 12-21 years of age	**PM 1:** Reducing Out-of-State Placements for Children in Foster Care **Measure steward:** Homegrown measure **Population:** Child and adolescent members in foster care
Aim	Will implementation of collaborative member, provider, and MCP interventions improve Annual Dental Visit rates among children ages 2-3 and Preventative Dental Services rates among children 1-20 enrolled in the Mountain Health Promise program?	Will the implementation of member, provider, and MCP interventions increase the rates of adolescent care, including well visits and immunizations received amongst members ages 9-21 enrolled with Aetna Better Health of West Virginia Mountain Health Promise?	Will implementation of comprehensive and collaborative member, provider, and MCP interventions reduce out-of-state placements for children in foster care?
Phase	Proposal	Proposal	Baseline

Key MCP improvement strategies and results for each PIP for the year under review are identified below.

MHT Annual Dental Visits PIP

ABHWV Interventions

ABHWV completed numerous targeted member, provider, and MCP interventions. Key interventions include:

- **Member incentive.** Provided members with a $25 gift card for completing a dental visit.
- **Gaps in care reports.** Issued monthly gaps in care reports to large provider organizations, which identified members in need of an annual dental visit.
- **Member outreach calls.** Informed members of dental service benefits, transportation services, and obtained updated member information.

- **Provider incentive.** Awarded high volume providers (financially) based upon annual dental visit compliance rates.
- **Annual cultural/health disparity analysis.** Completed an annual member cultural/health disparity analysis to better understand and respond to member needs.

ABHWV PIP Measure Results

Table 5 displays ABHWV's Annual Dental Visits PIP measure results and level of improvement. The COVID-19 public health emergency adversely influenced members seeking dental care and likely impacted MY 2020 performance for the dental PIP.

Table 5. ABHWV Annual Dental Visits PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Measurement Year MY 2020	Improvement	Statistically Significant Improvement
Annual Dental Visits for 2-3 Year Olds	37.73%	38.05%^	Yes	No
Percentage of Eligibles that Received Preventative Dental Services	48.85%	41.88%^	No	Ø

^ Performance was likely influenced by the COVID-19 public health emergency.
Ø - There was no improvement. Statistically significant improvement cannot be assessed.

THP Interventions

THP completed member, provider, and MCP interventions. Key interventions include:

- **Member incentive.** Provided members with a $25 gift card for a completed preventative dental service.
- **Alternate Payment Model Agreement.** Arranged an alternate payment agreement with a provider group, which included children's dental services as a targeted area for improvement.
- **Member education.** Mailed dental care awareness and education postcards to members during their birthday month.
- **Social media educational posts.** Encouraged general health and annual dental visits via quarterly social media posts. The posts also included safety precautions during the pandemic.
- **Provider education.** Provided education to primary care providers (PCPs)/pediatricians and encouraged them to reach out to parents/guardians of children on the importance of early dental health.

THP PIP Measure Results

Table 6 includes THP's Annual Dental Visits PIP measure results and level of improvement. The COVID-19 public health emergency adversely influenced members seeking dental care and likely impacted MY 2020 performance for the dental PIP.

Table 6. THP Annual Dental Visits PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Measurement Year MY 2020	Improvement	Statistically Significant Improvement
Annual Dental Visits for 2-3 Year Olds	27.40%	30.77%^	Yes	Yes
Percentage of Eligibles that Received Preventative Dental Services	34.89%	38.04%^	Yes	Yes

^ Performance was likely influenced by the COVID-19 public health emergency.

UHP Interventions

UHP completed member, provider, and MCP interventions. Key interventions include:

- **Text Message Reminders.** Texted messages to remind members to complete dental visits, stress the importance of dental care in children, and reassure members of dental office safety precautions during the pandemic.
- **Member Incentive.** Provided a $20 incentive reward for members 0-20 years who completed a dental exam.
- **Gaps in Care Reports.** Provided PCPs with a list of assigned members who were due for an annual dental visit, which provided opportunities for outreach and dentist referrals.
- **Provider Incentive Program.** Executed a PCP shared savings agreement with a provider group and included the Annual Dental Visits for 2-3 Year Olds measure and quality threshold in the program.

UHP PIP Measure Results

Table 7 reports UHP's Annual Dental Visits PIP measure results and level of improvement. The COVID-19 public health emergency adversely influenced members seeking dental care and likely impacted MY 2020 performance for the dental PIP.

Table 7. UHP Annual Dental Visits PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Measurement Year MY 2020	Improvement	Statistically Significant Improvement
Annual Dental Visits for 2-3 Year Olds	39.87%	33.84%^	No	Ø
Percentage of Eligibles that Received Preventative Dental Services	51.33%	43.42%^	No	Ø

^ Performance was likely influenced by the COVID-19 public health emergency.
Ø - There was no improvement. Statistically significant improvement cannot be assessed.

MHT MCP Annual Dental Visits PIP Weighted Average Measure Results

Table 8 details MHT MCP Annual Dental Visits PIP measure weighted averages for MYs 2017-2020.

Table 8. MHT MCP Weighted Averages - Annual Dental Visits PIP

Performance Measure	MY	Eligible Population or Denominator	Numerator	MHT MCP Weighted Average
Annual Dental Visits for 2-3 Year Olds	2017*	15,210	5,444	35.79%
	2018*	14,190	5,428	38.25%
	2019	11,057	4,429	40.06%
	2020	15,232	5,266	34.57%^
Percentage of Eligibles that Received Preventative Dental Services	2017*	201,428	91,663	45.51%
	2018*	194,497	93,065	47.85%
	2019	183,083	86,672	47.34%
	2020	176,797	73,757	41.72%^

* WV MHT weighted average includes a fourth MCP, West Virginia Family Health (WVFH). BMS ended its contract with WVFH on 6/30/2019.
^ Performance was likely influenced by the COVID-19 public health emergency.

Figure 1 displays annual individual MCP rates and MHT MCP weighted averages for the Annual Dental Visits for 2-3 Year Olds measure for MYs 2017-2020. After demonstrating consecutive annual improvements through MY 2019, the MY 2020 MHT MCP weighted average declined and compared unfavorably to baseline performance. This decline is likely due to the COVID-19 public health emergency.

Figure 1. Annual Dental Visits for 2-3 Year Olds - Annual Individual MCP Rates and MHT MCP Averages

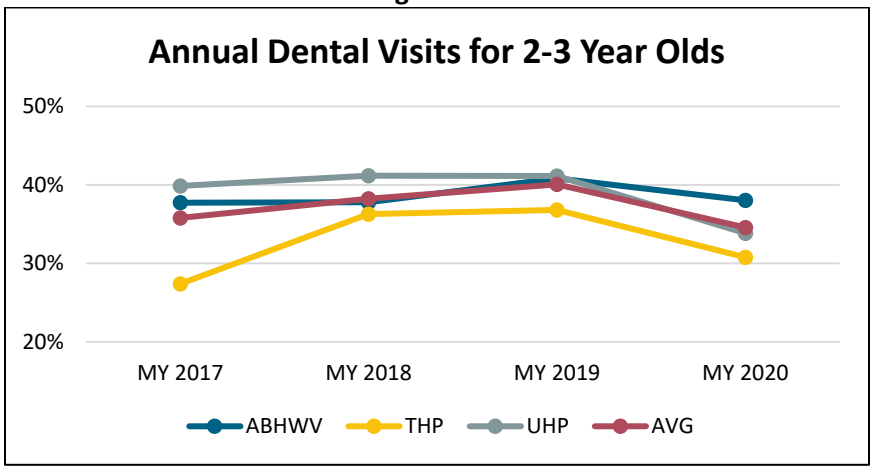
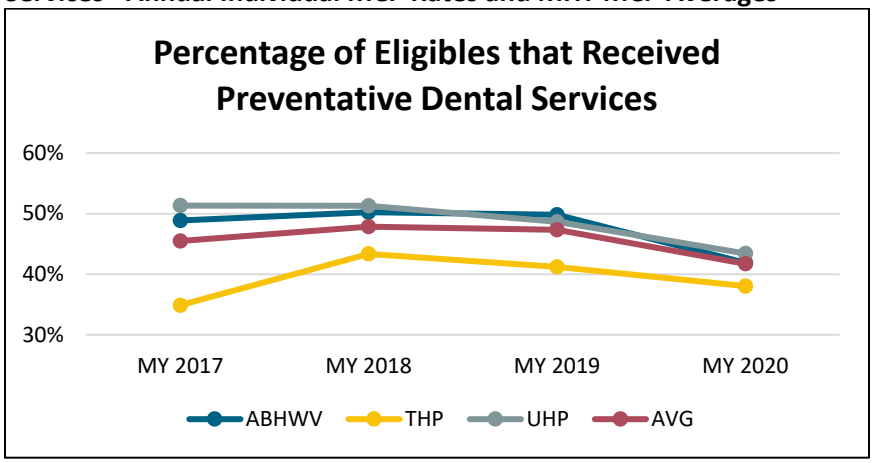


Figure 2 displays annual individual MCP rates and MHT MCP weighted averages for the Percentage of Eligibles that Received Preventative Dental Services measure for MYs 2017-2020. The MHT MCP weighted average peaked in MY 2018. The most recent MHT MCP weighted average measurement dropped below baseline performance.

Figure 2. Percentage of Eligibles that Received Preventative Dental Services - Annual Individual MCP Rates and MHT MCP Averages



MHT MCP Annual Dental Visits PIP Validation Results

Table 9 includes MCP results for each PIP validation step for the Annual Dental Visits PIP.

Table 9. MHT MCP PIP Validation Step Results - Annual Dental Visits PIP

PIP Validation Step	ABHWV	THP	UHP
Topic	Met	Met	Met
Aim Statement	Met	Met	Met
Population	Met	Met	Met
Sampling Method	Not Applicable	Not Applicable	Not Applicable
Variables and Performance Measures	Met	Met	Met
Data Collection Procedures	Met	Met	Met
Data Analysis and Interpretation of Results	Met	Partially Met	Met
Improvement Strategies	Partially Met	Partially Met	Met
Significant and Sustained Improvement	Partially Met	Met	Partially Met

Table 10 includes 2021 overall validation scores for each MCP's Annual Dental Visits PIP.

Table 10. MHT MCP Validation Scores - Annual Dental Visits PIP

2021 PIPs	ABHWV	THP	UHP	MHT MCP AVG
Validation Score	91%	95%	81%	89%
Confidence Level	High Confidence ❖	High Confidence ❖	Moderate Confidence ❖	Moderate Confidence ❖

MHT Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

ABHWV Interventions

ABHWV completed numerous targeted member, provider, and MCP interventions. Key interventions include:

- **Embedded Case Managers.** Placed case managers in behavioral health facilities, hospitals, and provider offices to schedule follow-up care for members.
- **Telehealth Expansion.** Expanded mental/behavioral health telehealth coverage for members to enhance access.
- **Peer Support Specialist.** Added a peer support specialist to the Behavioral Health Case Management team to work with members who have substance use challenges by providing education and support.
- **Case Management Reports.** Conducted outreach using reports, which included alerts for polypharmacy utilization, multiple prescribers, substance use disorder diagnosis, and high emergency department utilization in an attempt to enroll members in case management.
- **No cost transportation.** Promoted free transportation services to members during member outreach, gaps in care calls, case management calls, member newsletters, member website, and the Member Handbook.

ABHWV PIP Measure Results

Table 11 displays ABHWV's Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP measure results.

Table 11. ABHWV Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2020	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day Follow-Up (Total)	42.26%	47.63%^	Yes	Yes

^ Performance was likely influenced by the COVID-19 public health emergency.

THP Interventions

THP completed member, provider, and MCP interventions. Select interventions include:

- **Telehealth services.** Covered telehealth and teledoc visits to enhance access during the COVID-19 public health emergency.
- **Referrals to Care Navigation.** Identified members with substance use during health risk assessments and referred them to case management nurses and navigation teams for engagement.

- **Utilization notifications.** Received member event notifications pertaining to admissions, discharges, transfers, and emergency department utilization. Notices were provided to case managers for follow-up.
- **Health library resource.** Maintained a health library on the MCP website, which linked members to educational materials and resources regarding alcohol and substance use disorders. The website also outlined available services including complex case management and care navigation nurses and assistance in accessing care and treatment for alcohol and substance use disorders.

THP PIP Measure Results

Table 12 reports THP's Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP measure results.

Table 12. THP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2020	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day Follow-Up (Total)	41.04%	50.28%^	Yes	Yes

^ Performance was likely influenced by the COVID-19 public health emergency.

UHP Interventions

UHP completed member, provider, and MCP interventions, some of which include:

- **Telemedicine program.** Provided on-demand access to a medication-assisted treatment program. PCPs can refer members for an assessment for substance use disorder treatment or members can be connected, on-demand, with a provider prior to leaving the emergency department.
- **Behavioral health quality incentive program.** Incentivized providers for efficiency and quality of care and performance in the Follow-Up After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence measure, among others.
- **Provider Education.** Reached out to and educated providers on the Follow Up-After Emergency Department Visit for Alcohol or Other Drug Abuse or Dependence measure specifications, timeline adherence, coding guidelines, and importance of care coordination.
- **Case management referrals.** Monitored daily emergency department visits and made case management referrals for members with the goal of engaging members in treatment, assisting with scheduling follow-up appointments, and arranging transportation.

UHP PIP Measure Results

Table 13 includes UHP's Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP measure results.

Table 13. UHP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Measurement Year MY 2020	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day Follow-Up (Total)	42.32%	48.69%^	Yes	Yes

^ Performance was likely influenced by the COVID-19 public health emergency.

MHT MCP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Weighted Average Measure Results

Table 14 includes the MHT MCP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP measure weighted averages for MYs 2019-2020.

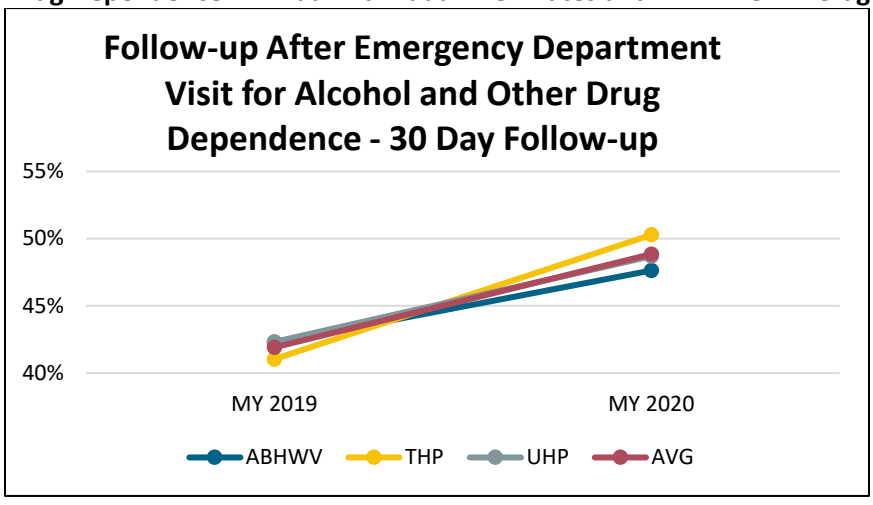
Table 14. MHT MCP Weighted Average - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

Performance Measure	MY	Eligible Population or Denominator	Numerator	MHT MCP Weighted Average
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day Follow-Up (Total)	2019	3,498	1,466	41.91%
	2020	4,033	1,970	48.85%^

^ Performance was likely influenced by the COVID-19 public health emergency.

Figure 3 displays annual individual MCP rates and MHT MCP weighted averages for the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence measure for MYs 2019-2020. All MCPs demonstrated statistically significant improvement in the PIP measure.

Figure 3. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - Annual Individual MCP Rates and MHT MCP Averages



MHT MCP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Validation Results

Table 15 includes MCP results for each PIP validation step for the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP.

Table 15. MHT MCP PIP Validation Step Results - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

PIP Validation Step	ABHWV	THP	UHP
Topic	Met	Met	Met
Aim Statement	Partially Met	Met	Partially Met
Population	Met	Met	Met
Sampling Method	Not Applicable	Not Applicable	Not Applicable
Variables and Performance Measures	Met	Met	Met
Data Collection Procedures	Met	Met	Met
Data Analysis and Interpretation of Results	Met	Met	Met
Improvement Strategies	Met	Partially Met	Met
Significant and Sustained Improvement	Met	Met	Met

Table 16 includes 2021 overall validation scores for each MCP's Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP.

Table 16. MHT MCP Validation Scores - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

2021 PIPs	ABHWV	THP	UHP	MHT MCP AVG
Validation Score	99%	96%	99%	98%
Confidence Level	High Confidence ❖	High Confidence ❖	High Confidence ❖	High Confidence ❖

MHT MCP Selected PIPs

ABHWV Care for Adolescents PIP Interventions

ABHWV did not report interventions; they are not required for a baseline PIP submission. ABHWV will report interventions in its next annual PIP report.

ABHWV Care for Adolescents PIP Measure Results

Table 17 displays ABHWV's Care for Adolescents PIP measure results. Improvement cannot be assessed until the next annual remeasurement period.

Table 17. ABHWV Care for Adolescents PIP Measure Results

Performance Measure	Baseline Year MY 2020	Last Measurement Year	Improvement	Statistically Significant Improvement
Immunizations for Adolescents - Combination 2	27.67%^	NA	NA	NA
Child and Adolescent Well-Care Visits – 12-17 Year Olds	49.03%^	NA	NA	NA
Child and Adolescent Well-Care Visits – 18-21 Year Olds	27.13%^	NA	NA	NA

^ Performance was likely influenced by the COVID-19 public health emergency.
NA - Not Applicable - Only baseline results are available.

Table 18 includes ABHWV's Care for Adolescents PIP measure baseline rates.

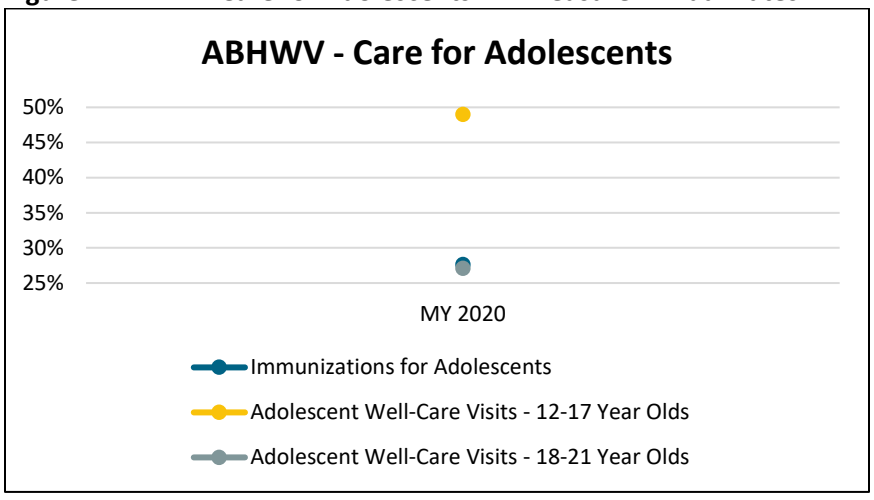
Table 18. ABHWV Care for Adolescents PIP Measure Annual Rates

Performance Measure	MY	Eligible Population or Denominator	Numerator	Rate
Immunizations for Adolescents - Combination 2	2020	2,161	598	27.67%^
Child and Adolescent Well-Care Visits – 12-17 Year Olds	2020	13,594	6,665	49.03%^
Child and Adolescent Well-Care Visits – 18-21 Year Olds	2020	5,268	1,429	27.13%^

^ Performance was likely influenced by the COVID-19 public health emergency.

Figure 4 illustrates ABHWV's Care for Adolescents PIP measure baseline rates.

Figure 4. ABHWV Care for Adolescents PIP Measure Annual Rates



THP Promoting Health and Wellness in Children and Adolescents PIP Interventions

THP completed member, provider, and MCP interventions. Key interventions include:

- **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.
- **Member incentive.** Provided members who completed an adolescent well-care visit a $25 gift card.
- **Provider gaps in care reports.** Identified members in need of an annual well-care visit and distributed information to PCPs.
- **Alternate Payment Model Agreement.** Arranged an alternate payment agreement with selected providers, which included well-care visits as a targeted area for improvement.

THP Promoting Health and Wellness in Children and Adolescents PIP Measure Results

Table 19 reports THP's Promoting Health and Wellness in Children and Adolescents PIP measure results and level of improvement.

Table 19. THP Promoting Health and Wellness in Children and Adolescents PIP Measure Results

Performance Measure	Baseline Year○	Last Measurement Year MY 2020	Improvement	Statistically Significant Improvement
Child and Adolescent Well-Care Visits – Total	MY 2020 44.42%^	NA	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile Documentation	MY 2018 77.62%	80.54%^	Yes	No
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	MY 2018 67.88%	69.34%^	Yes	No

○ The Child and Adolescent Well-Care Visits measure has a different baseline year compared to the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measures, as it is new for the PIP.
^ Performance was likely influenced by the COVID-19 public health emergency.
NA - Not Applicable - Only baseline results are available

Table 20 includes THP's annual Promoting Health and Wellness in Children and Adolescents PIP measure rates.

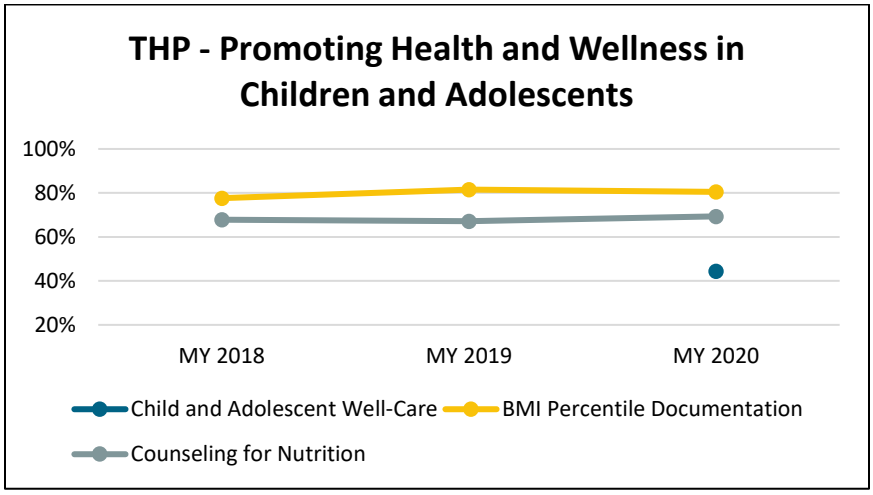
Table 20. THP Promoting Health and Wellness in Children and Adolescents PIP Measure Annual Rates

Performance Measure	MY	Eligible Population or Denominator⅄	Numerator	Rate
Child and Adolescent Well-Care Visits – Total	2020	27,539	12,232	44.42%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile Documentation	2018	411	319	77.62%
	2019	411	335	81.51%
	2020	411	331	80.54%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	2018	411	279	67.88%
	2019	411	276	67.15%
	2020	411	285	69.34%^

⅄ Sampling denominator
^ Performance was likely influenced by the COVID-19 public health emergency.

Figure 5 illustrates THP's Promoting Health and Wellness in Children and Adolescents PIP measure annual rates.

Figure 5. THP Promoting Health and Wellness in Children and Adolescents PIP Measure Annual Rates



UHP Immunizations for Adolescents PIP Interventions

UHP did not report interventions; they are not required for a baseline PIP submission. UHP will report interventions in its next annual PIP report.

UHP Immunizations for Adolescents PIP Measure Results

Table 21 displays UHP's Immunizations for Adolescents PIP measure results. Improvement cannot be assessed until the next annual remeasurement period.

Table 21. Immunization for Adolescents PIP Measure Results

Performance Measure	Baseline Year MY 2020	Last Measurement Year	Improvement	Statistically Significant Improvement
Immunizations for Adolescents – Combination 2	29.93%^	NA	NA	NA
Immunizations for Adolescents – Human Papillomavirus (HPV)	30.41%^	NA	NA	NA

^ Performance was likely influenced by the COVID-19 public health emergency.
NA - Not Applicable - Only baseline results are available

Table 22 includes UHP's Immunization for Adolescents PIP measure annual rates.

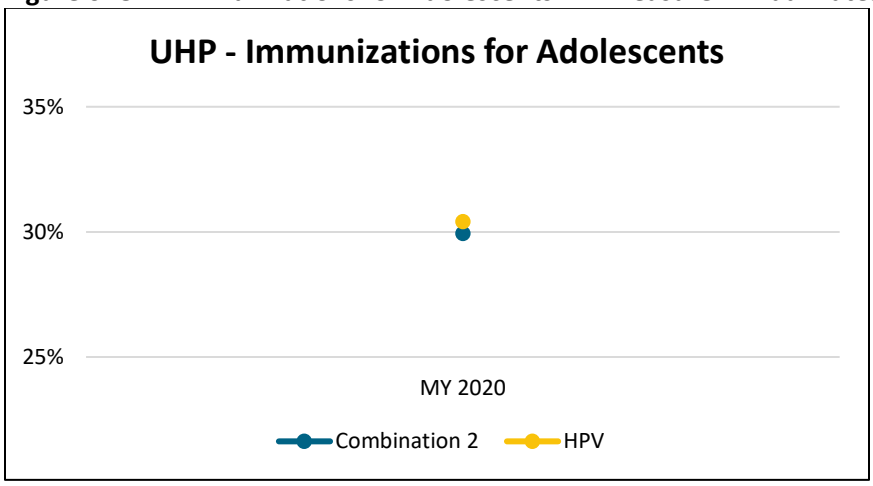
Table 22. UHP Immunizations for Adolescents PIP Measure Annual Rates

Performance Measure	MY	Eligible Population or Denominator⅄	Numerator	Rate
Immunizations for Adolescents – Combination 2	2020	411	123	29.93%
Immunizations for Adolescents – Human Papillomavirus (HPV)	2020	411	125	30.41%

⅄ Sampling denominator

Figure 6 displays UHP's Immunizations for Adolescents PIP measure baseline rates.

Figure 6. UHP Immunizations for Adolescents PIP Measure Annual Rates



MHT MCP Selected PIP Validation Results

Table 23 reports results for each validation step for each MHT MCP's selected PIP.

Table 23. MHT MCP PIP Validation Step Results – MHT MCP Selected PIP

2021 MCP Selected PIPs	ABHWV	THP	UHP
PIP Validation Step	Care for Adolescents	Promoting Health and Wellness in Children and Adolescents	Immunizations for Adolescents
Topic	Met	Met	Met
Aim Statement	Partially Met	Partially Met	Met
Population	Met	Met	Met
Sampling Method	Not Applicable	Met	Met
Variables and Performance Measures	Met	Met	Met
Data Collection Procedures	Met	Met	Met
Data Analysis and Interpretation of Results	Partially Met	Partially Met	Met
Improvement Strategies	Not Applicable	Partially Met	Not Applicable
Significant and Sustained Improvement	Not Applicable	Partially Met	Not Applicable

Table 24 includes 2021 overall validation scores for each MCP's selected PIP.

Table 24. MHT MCP Validation Scores – MCP Selected PIP

2021 PIPs	ABHWV Care for Adolescents	THP Promoting Health and Wellness in Children and Adolescents	UHP Immunizations for Adolescents	MHT MCP AVG
Validation Score	92%	85%	100%	92%
Confidence Level	High Confidence ❖	Moderate Confidence ❖	High Confidence ❖	High Confidence ❖

MHP Annual Dental Visits PIP

MHP ABHWV Interventions

ABHWV's Annual Dental Visits PIP was a proposal submission and did not include interventions due to the program implementation date of March 1, 2020.

MHP ABHWV PIP Measure Results

ABHWV's Annual Dental Visits PIP did not include baseline results due to the recent program implementation. Table 25 displays the Annual Dental Visits PIP measures. Baseline performance will be reported in the next annual PIP submission.

Table 25. MHP ABHWV Annual Dental Visits PIP Measure Results

Performance Measure	Baseline Year	Last Measurement Year	Improvement	Statistically Significant Improvement
Annual Dental Visits for 2-3 Year Olds	NA	NA	NA	NA
Percentage of Eligibles that Received Preventative Dental Services	NA	NA	NA	NA

NA - Not Applicable – Baseline performance is not available due to the March 1, 2020 program implementation.

MHP Care for Adolescents PIP

MHP ABHWV Interventions

ABHWV's Care for Adolescents PIP was a proposal submission and did not include interventions due to the program implementation date of March 1, 2020.

MHP ABHWV PIP Measure Results

ABHWV's Care for Adolescents PIP was a proposal submission and did not include baseline results due to the recent program implementation. Table 26 displays the Care for Adolescents PIP measures. Baseline performance will be reported in the next annual PIP submission.

Table 26. MHP ABHWV Care for Adolescents PIP Measure Results

Performance Measure	Baseline Year	Last Measurement Year	Improvement	Statistically Significant Improvement
Immunizations for Adolescents - Combination 2	NA	NA	NA	NA
Child and Adolescent Well-Care Visits – 12-17 Year Olds	NA	NA	NA	NA
Child and Adolescent Well-Care Visits – 18-21 Year Olds	NA	NA	NA	NA

NA - Not Applicable – Baseline performance is not available due to the March 1, 2020 program implementation.

MHP Reducing Out-of-State Placements for Children in Foster Care PIP

MHP ABHWV Reducing Out-of-State Placements for Children in Foster Care PIP Interventions

ABHWV did not report interventions; they are not required for a baseline PIP submission. ABHWV will report interventions in its next annual PIP report.

MHP ABHWV Reducing Out-of-State Placements for Children in Foster Care PIP Measure Results

ABHWV reported baseline performance for the Reducing Out-of-State Placements for Children in Foster Care PIP due to being able to obtain the annual rate from the State of West Virginia Department of

Health and Human Services Legislative Foster Care Placements Report. While the first two months of the annual rate calculation were outside of the MHP contract period, it was determined the rate serves as a true baseline and was approved for use in the PIP. Table 27 displays ABHWV's Out-of-State Placements for Children in Foster Care PIP measure results. Improvement cannot be assessed until the next annual remeasurement period.

Table 27. MHP ABHWV Reducing Out-of-State Placements for Children in Foster Care PIP Measure Results

Performance Measure	Baseline Year MY 2020	Last Measurement Year	Improvement	Statistically Significant Improvement
Out-of-State Placements for Children in Foster Care	5.98%	NA	NA	NA

NA - Not Applicable - Only baseline results are available.

Table 28 includes ABHWV's Reducing Out-of-State Placements for Children in Foster Care PIP measure baseline rate.

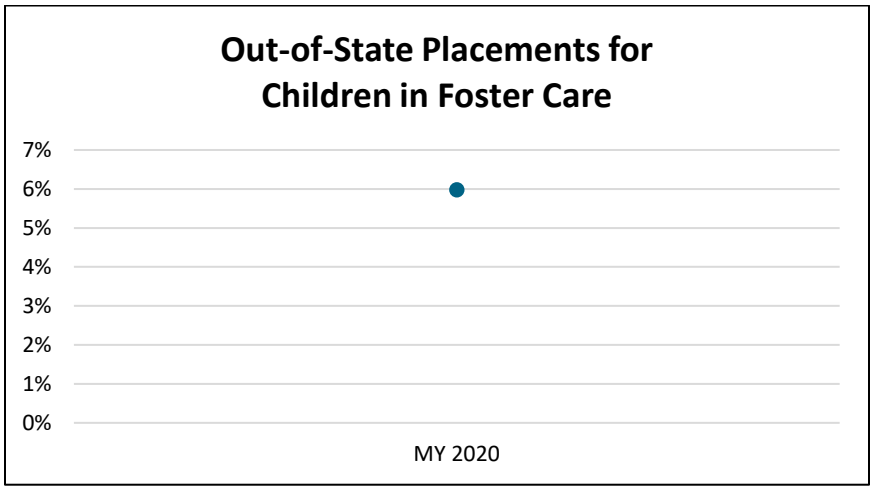
Table 28. MHP ABHWV Reducing Out-of-State Placements for Children in Foster Care PIP Measure Annual Rate

Performance Measure	MY	Eligible Population or Denominator	Numerator	Rate
Out-of-State Placements for Children in Foster Care	2020	6,870	411	5.98%

NA - Not Applicable - Only baseline results are available.

Figure 7 displays ABHWV's Reducing Out-of-State Placements for Children in Foster Care PIP measure baseline rate.

Figure 7. MHP ABHWV Reducing Out-of-State Placements for Children in Foster Care PIP Measure Annual Rate



MHP PIP Validation Results

Table 29 reports results for each validation step for each MHP PIP.

Table 29. MHP ABHWV PIP Validation Step Results

PIP Validation Step	Annual Dental Visits	Care for Adolescents	Reducing Out-of-State Placements for Children in Foster Care
Topic	Met	Met	Met
Aim Statement	Met	Partially Met	Partially Met
Population	Met	Met	Met
Sampling Method	Not Applicable	Not Applicable	Not Applicable
Variables and Performance Measures	Met	Met	Met
Data Collection Procedures	Met	Met	Met
Data Analysis and Interpretation of Results	Met	Met	Met
Improvement Strategies	Not Applicable	Not Applicable	Not Applicable
Significant and Sustained Improvement	Not Applicable	Not Applicable	Not Applicable

Table 30 includes 2021 overall validation scores for each MHP PIP.

Table 30. MHP ABHWV Validation Scores

2021 PIPs	Annual Dental Visits	Care for Adolescents	Reducing Out-of-State Placements for Children in Foster Care
Validation Score	100%	98%	98%
Confidence Level	High Confidence ❖	High Confidence ❖	High Confidence ❖

Conclusion

Summary conclusions drawn for the MHT and MHP State mandated and MCP selected PIPs are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 48-51 within the MCP Quality, Access, Timeliness Assessment section, later in the report.

MHT Annual Dental Visits PIP

- The MHT MCPs reported their third remeasurement rates for the Annual Dental Visits PIP.
- The COVID-19 public health emergency adversely influenced members seeking dental care and likely impacted MY 2020 performance for the dental PIP—more than other areas of care.
- The MHT MCP weighted average demonstrated sustained improvement in both dental measures until this last year of reporting when both measures failed to exceed baseline

performance.[12] The MCPs were challenged by barriers and constraints related to the public health emergency.
- The MCPs received an average PIP validation score of 89%, indicating (overall) stakeholders can have moderate confidence the MCPs adhered to acceptable methodology for all phases of design, data collection, and analysis with results yielding improvement. Individual MCP validation results ranged from 81%-95%.

MHT Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

- The MHT MCPs reported their first measurement rates for the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP.
- The MCPs all demonstrated statistically significant improvement in the PIP. The MHT MCP weighted average increased from 41.91% to 48.85%.
- Telehealth services improved access to care for follow-up visits.
- The MHT MCPs received an average PIP validation score of 98% (high confidence). Individual MCP validation scores ranged from 96%-99%.

MHT MCP Selected PIPs

ABHWV Care for Adolescents PIP

- ABHWV reported baseline results for its Care for Adolescents PIP measures, Immunizations for Adolescents (Combination 2), and Child and Adolescent Well-Care Visits (12-17 and 18-21 Year Olds).
- ABHWV's validation score was 92% (high confidence).

THP Promoting Health and Wellness in Children and Adolescents PIP

- THP reported a baseline result for the Child and Adolescent Well-Care Visits (Total) measure and remeasurement two results for its Weight Assessment and Counseling for Nutrition - BMI Percentile Documentation and Counseling for Nutrition measures. MY 2020 results exceeded baseline performance in both measures.
- THP's validation score was 85% (moderate confidence).

UHP Immunizations for Adolescents PIP

- UHP reported baseline results for its Immunizations for Adolescents - Combination 2 and HPV measures.
- UHP's validation score was 100% (high confidence).

[12] Sustained improvement means all remeasurements demonstrated improvement compared to baseline performance.

MHP ABHWV PIPs

Annual Dental Visits PIP

- MHP ABHWV's Annual Dental Visits PIP was a proposal submission and did not include baseline results due to the program implementation date of March 1, 2020.
- MHP ABHWV's validation score was 100% (high confidence).

Care for Adolescents PIP

- MHP ABHWV's Care for Adolescents PIP was a proposal submission and did not include baseline results due to the program implementation date of March 1, 2020.
- MHP ABHWV's validation score was 98% (high confidence).

Reducing Out-of-State Placements for Children in Foster Care PIP

- MHP ABHWV's Reducing Out-of-State Placements for Children in Foster Care PIP was a proposal submission and included baseline performance. Baseline results were permitted as data for the entire 2020 measurement year was obtained from the State of West Virginia Department of Health and Human Services Legislative Foster Care Placements Report. While the first two months of the annual rate calculation were outside of the MHP contract period, it was determined the rate serves as a true baseline and was approved for use in the PIP.
- MHP ABHWV's validation score was 98% (high confidence).

Performance Measure Validation

Objective

The State uses PMs to monitor the performance of individual MCPs at a point in time, track performance over time, and compare performance among MCPs. BMS requires MCPs calculate and report measures as part of their quality assessment and performance improvement program in accordance with 42 CFR §438.330(c).The PMV activity evaluates the accuracy and reliability of measures produced and reported by the MCP and determines the extent to which the MCP followed specifications for calculating and reporting the measures. Accuracy and reliability of the reported rates are essential to ascertaining whether the MCP's quality improvement efforts resulted in improved health outcomes. Further, the validation process allows BMS to have confidence in MCP measure results.

Methodology

Qlarant validated BMS-selected PMs during the 2021 PMV activity. Designated HEDIS, CAHPS, and CMS Core Set measures were used to calculate MY 2020 MHT and MHP performance.

Description of Data Obtained. Information from several sources was used to satisfy validation requirements. These sources included, but were not limited to, the following documents and information provided by the MCP:

- Information Systems Capabilities Assessment
- HEDIS Record of Administration, Data Management and Processes (Roadmap)
- HEDIS Final Audit Report, if available
- Other documentation (e.g. specifications, data dictionaries, program source code, data queries, policies, and procedures)
- Demonstrations during the onsite visit
- Interviews with MCP staff
- Information submitted as part of the follow-up items requested after the onsite visit

Technical Methods of Data Collection and Analysis. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 2 – Validation of Measures*.[13]

The validation process was interactive and concurrent to the MCP calculating the measures. Validation activities occurred before, during, and after an onsite visit to the MCP and included two principle components:

- An overall assessment of the MCP's information systems (IS) capability to capture and process data required for reporting
- An evaluation of the MCP's processes (e.g. source code programs) used to prepare each measure

Essential PMV activities included:

- Review of the MCP's data systems and processes used to construct the measures
- Assessment of the calculated rates for algorithmic compliance to required specifications
- Verification the reported rates were reliable and based on accurate sources of information

Qlarant conducted onsite MCP PMV review activities via virtual desk audit in March 2021 and concluded all post-onsite review activities in June 2021 when MCPs reported final measure rates. After Qlarant approved each MCP's final rates, Qlarant reported findings for the following audit elements including: documentation (data integration and control and calculation process), denominator, numerator, sampling (if applicable), and reporting. Audit element descriptions are provided below.

Documentation. Assessment of data integration and control procedures determine whether the MCP had appropriate processes and documentation in place to extract, link, and manipulate data for accurate and reliable measure rate construction. Evaluation includes reviewing and assessing documentation of measurement procedures and programming specifications including data sources, programming logic, and computer source codes.

Denominator. Validation of measure denominator calculations assesses the extent to which the MCP used appropriate and complete data to identify the entire population and the degree to which the MCP followed measures specifications for calculating the denominator.

[13] CMS EQRO Protocols

Numerator. Validation of the numerator determines if the MCP correctly identified and evaluated all qualifying medical events for appropriate inclusion or exclusion in the numerator for each measure and if the MCP followed measure specifications for calculation of the numerator.

Sampling. Evaluation of sample size and replacement methodology specifications confirms the sample was not biased, if applicable.

Reporting. Validation of measure reporting confirms if the MCP followed BMS specifications.

Qlarant calculated a validation rating for the MCP based on audit element findings. The rating provides a level of confidence in the MCP's reported PM results. Validation ratings include:

- ❖ 95% - 100%: high confidence in MCP results
- ❖ 80% - 94%: moderate confidence in MCP results
- ❖ 75% - 79%: low confidence in MCP results
- ❖ ≤74%: no confidence in MCP results

Results

MHT Performance Measure Validation Results

All MHT MCPs had appropriate systems in place to process accurate claims and encounters. Table 31 includes 2021 MHT PMV results based on the MCP calculation of MY 2020 measure rates. Compliance with each PMV element is reported by MCP and MHT MCP average.

Table 31. MHT MCP PMV Results

PMV Element	ABHWV	THP	UHP	MHT MCP Average
Data Integration and Control	100%	100%	100%	100%
Data and Process Used to Produce Measures	100%	100%	100%	100%
Denominator	100%	100%	100%	100%
Numerator	100%	100%	100%	100%
Sampling	100%	100%	100%	100%
Reporting	100%	100%	100%	100%
Overall Rating	100%	100%	100%	100%
Reporting Designation	R	R	R	R¨
Level of Confidence	High Confidence ❖	High Confidence ❖	High Confidence ❖	High Confidence ❖

R – Reportable; measures were compliant with BMS specifications.
¨ All MCPs received a reportable designation.

Table 32 displays the MHT MCP MY 2020 performance measure rates. The table reports each measure's data collection methodology for informational purposes.

Table 32. MHT MCP Performance Measure Rates for MY 2020

Performance Measure	Data Collection Method*	ABHWV MY 2020 Rate+	THP MY 2020 Rate	UHP MY 2020 Rate
Annual Dental Visits for 2-3 Year Olds	Administrative	38.32%	30.77%	33.84%
Cervical Cancer Screening	Hybrid	53.04%	40.15%	53.28%
Child and Adolescent Well-Care Visits - Ages 3-11 Years Old	Administrative	56.72%	51.54%	51.49%
Child and Adolescent Well-Care Visits - Ages 12-17 Years Old	Administrative	49.68%	41.55%	42.35%
Child and Adolescent Well-Care Visits - Ages 18-21 Years Old	Administrative	27.23%	24.10%	20.87%
Child and Adolescent Well-Care Visits - Total	Administrative	50.89%	44.42%	44.27%
Childhood Immunization Status: Combination 3	Hybrid	71.05%	67.64%	74.70%
Comprehensive Diabetes Care: Eye Exams	Hybrid	33.33%	36.74%	36.25%
Contraceptive Care - All Women Ages 15-20 Long-Acting Reversible Method of Contraception	Administrative	4.71%	3.55%	3.40%
Contraceptive Care - All Women Ages 15-20 Most or Moderately Effective Method of Contraception	Administrative	39.20%	37.87%	37.94%
Contraceptive Care - All Women Ages 21-44 Long-Acting Reversible Method of Contraception	Administrative	3.69%	3.08%	3.44%
Contraceptive Care - All Women Ages 21-44 Most or Moderately Effective Method of Contraception	Administrative	23.46%	22.18%	24.23%
Contraceptive Care - Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 3 Days	Administrative	2.72%	1.54%	2.82%
Contraceptive Care - Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 60 Days	Administrative	13.29%	9.74%	10.09%
Contraceptive Care - Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 3 Days	Administrative	5.44%	4.10%	5.40%

Performance Measure	Data Collection Method*	ABHWV MY 2020 Rate+	THP MY 2020 Rate	UHP MY 2020 Rate
Contraceptive Care - Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 60 Days	Administrative	51.06%	47.18%	44.13%
Contraceptive Care - Postpartum Women Ages 21-44 Long-Acting Reversible Method of Contraception, 3 Days	Administrative	2.55%	2.84%	2.19%
Contraceptive Care - Postpartum Women Ages 21-44 Long-Acting Reversible Method of Contraception, 60 Days	Administrative	10.11%	9.10%	8.31%
Contraceptive Care - Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception, 3 Days	Administrative	17.95%	17.28%	15.58%
Contraceptive Care - Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception, 60 Days	Administrative	47.52%	45.18%	44.96%
Dental Sealants for 6-9 Year Old Children at Elevated Risk	Administrative	16.79%	17.39%	75.87%
Developmental Screening in the First Three Years of Life - Age 1	Administrative	19.35%	13.93%	18.45%
Developmental Screening in the First Three Years of Life - Age 2	Administrative	17.79%	13.34%	19.15%
Developmental Screening in the First Three Years of Life - Age 3	Administrative	16.88%	11.83%	17.12%
Developmental Screening in the First Three Years of Life - Total	Administrative	18.06%	13.08%	18.21%
Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up	Administrative	47.18%	50.28%	48.69%
Follow-Up After Emergency Department Visit for Mental Illness: 30 Days Follow-Up	Administrative	52.00%	48.50%	50.08%
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up	Administrative	65.71%	59.98%	62.41%
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit	Survey	70.07%	70.83%	74.60%
Percentage of Eligible (Children) that Received Preventive Dental Services	Administrative	44.03%	38.04%	43.42%

Performance Measure	Data Collection Method*	ABHWV MY 2020 Rate+	THP MY 2020 Rate	UHP MY 2020 Rate
PQI 01: Diabetes Short-Term Complications Admission Rate ***Lower rate is better***	Administrative	19.18	26.32	20.82
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate ***Lower rate is better***	Administrative	36.77	41.44	37.10
PQI 08: Congestive Heart Failure (CHF) Admission Rate ***Lower rate is better***	Administrative	22.36	25.94	20.38
PQI 15: Asthma in Younger Adults Admission Rate ***Lower rate is better***	Administrative	1.27	1.42	1.23
Prenatal and Postpartum Care: Postpartum Care	Hybrid	77.62%	69.59%	75.91%
Use of Imaging Studies for Low Back Pain	Administrative	66.38%	65.54%	69.27%
Well-Child Visits in the First 30 Months of Life - 0-15 Months	Administrative	57.50%	57.05%	41.13%
Well-Child Visits in the First 30 Months of Life - 15-30 Months	Administrative	74.22%	71.47%	73.49%

* Administrative data collection: rates are calculated using claims and other supplemental data. Hybrid data collection: rates are calculated using administrative and medical record data.
+ ABHWV's HEDIS measure rates reflect performance in all Medicaid populations (MHT and MHP) per NCQA reporting requirements.

Table 33 details the MY 2020 MHT MCP weighted average for each measure and compares performance to national benchmarks. The table includes the aggregate eligible population and numerator for each measure.

Table 33. MHT MCP Performance Measure Rates for MY 2020

Performance Measure	Eligible Population	Numerator	MHT MY 2020 Weighted Average	Comparison to Benchmarks*
Annual Dental Visits for 2-3 Year Olds	15,362	5,330	34.70%	♦♦
Cervical Cancer Screening	103,595	51,426	49.64%	♦
Child and Adolescent Well-Care Visits - Ages 3-11 Years Old	69,416	37,024	53.34%	♦♦
Child and Adolescent Well-Care Visits - Ages 12-17 Years Old	43,064	19,182	44.54%	♦
Child and Adolescent Well-Care Visits - Ages 18-21 Years Old	16,876	3,984	23.61%	♦
Child and Adolescent Well-Care Visits - Total	129,356	60,190	46.53%	♦♦
Childhood Immunization Status: Combination 3	5,794	4,157	71.75%	♦♦

Performance Measure	Eligible Population	Numerator	MHT MY 2020 Weighted Average	Comparison to Benchmarks*
Comprehensive Diabetes Care: Eye Exams	22,709	8,036	35.39%	♦
Contraceptive Care - All Women Ages 15-20 Long-Acting Reversible Method of Contraception	15,507	597	3.85%	♦~
Contraceptive Care - All Women Ages 15-20 Most or Moderately Effective Method of Contraception	15,507	5,943	38.32%	♦♦♦~
Contraceptive Care - All Women Ages 21-44 Long-Acting Reversible Method of Contraception	66,373	2,276	3.43%	♦^
Contraceptive Care - All Women Ages 21-44 Most or Moderately Effective Method of Contraception	66,373	15,551	23.43%	♦^
Contraceptive Care - Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 3 Days	952	24	2.52%	♦~
Contraceptive Care - Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 60 Days	952	106	11.13%	♦~
Contraceptive Care - Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 3 Days	952	49	5.15%	♦~
Contraceptive Care - Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 60 Days	952	449	47.16%	♦♦~
Contraceptive Care - Postpartum Women Ages 21-44 Long-Acting Reversible Method of Contraception, 3 Days	6,329	156	2.46%	♦♦^
Contraceptive Care - Postpartum Women Ages 21-44 Long-Acting Reversible Method of Contraception, 60 Days	6,329	576	9.10%	♦^
Contraceptive Care - Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception, 3 Days	6,329	1,062	16.78%	♦♦♦^

Performance Measure	Eligible Population	Numerator	MHT MY 2020 Weighted Average	Comparison to Benchmarks*
Contraceptive Care - Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception, 60 Days	6,329	2,903	45.87%	♦♦^
Dental Sealants for 6-9 Year Old Children at Elevated Risk	19,616	8,281	42.22%	♦♦♦~
Developmental Screening in the First Three Years of Life - Age 1	7,246	1,278	17.64%	NBA
Developmental Screening in the First Three Years of Life - Age 2	5,798	1,004	17.32%	NBA
Developmental Screening in the First Three Years of Life - Age 3	6,533	1,032	15.80%	NBA
Developmental Screening in the First Three Years of Life - Total	19,577	3,314	16.93%	♦~
Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up	4,054	1,974	48.69%	♦♦♦
Follow-Up After Emergency Department Visit for Mental Illness: 30 Days Follow-Up	1,734	873	50.35%	♦
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up	3,703	2,334	63.03%	♦♦
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit	Survey	Survey	71.83%	♦
Percentage of Eligible (Children) that Received Preventive Dental Services	196,858	83,842	42.59%	♦♦~
PQI 01: Diabetes Short-Term Complications Admission Rate ***Lower rate is better***	2,929,883	637	21.74	♦♦^
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate ***Lower rate is better***	1,311,384	501	38.20	♦♦♦^
PQI 08: Congestive Heart Failure (CHF) Admission Rate ***Lower rate is better***	2,929,883	661	22.56	♦♦^
PQI 15: Asthma in Younger Adults Admission Rate ***Lower rate is better***	1,618,499	21	1.30	♦♦♦^
Prenatal and Postpartum Care: Postpartum Care	8,302	6,225	74.98%	♦

Performance Measure	Eligible Population	Numerator	MHT MY 2020 Weighted Average	Comparison to Benchmarks*
Use of Imaging Studies for Low Back Pain	4,989	1,627	67.39%	♦
Well-Child Visits in the First 30 Months of Life - 0-15 Months	6,344	3,211	50.61%	♦
Well-Child Visits in the First 30 Months of Life - 15-30 Months	6,000	4,396	73.27%	♦♦

* Benchmark data source: Quality Compass 2021 (MY 2020 data) National Medicaid Average for Health Maintenance Organizations
~ Benchmark data source: Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set Chart Pack, November 2021
^ Benchmark data source: Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set Chart, November 2021
♦ The MHT Average is below the National Average
♦♦ The MHT Average is equal to or exceeds the National Average, but does not meet the 75th Percentile
♦♦♦ The MHT Average is equal to or exceeds the 75th Percentile
NBA - No Benchmark Available

MHP Performance Measure Validation Results

Similar to the MHT PMV, ABHWV had appropriate systems in place to process accurate claims and encounters for the MHP program. Table 34 includes 2021 MHP PMV results based on the MCP calculation of MY 2020 measure rates. Compliance with each PMV element is reported.

Table 34. MHP ABHWV PMV Results

PMV Element	ABHWV
Data Integration and Control	100%
Data and Process Used to Produce Measures	100%
Denominator	100%
Numerator	100%
Sampling	100%
Reporting	100%
Overall Rating	100%
Reporting Designation	R
Level of Confidence	High Confidence ❖

R – Reportable; measures were compliant with BMS specifications

Table 35 displays each MHP PM data collection method, eligible population, numerator, rate, and comparison to national benchmarks for MY 2020. Due to the MHP program implementation date of March 1, 2020, the number of PMs available for reporting was limited due to continuous enrollment specifications.

Table 35. MHP ABHWV Performance Measure Rates for MY 2020

Performance Measure	Data Collection Method*	Eligible Population	Numerator	ABHWV MY 2020 Rate	Comparison to Benchmarks~
Ambulatory Care: Emergency Department Visits – 0-19 Years (Visits per 1,000 Member Months) ***Lower rate is better***	Administrative	192,509 Member Months	4,643 Visits	24.12	♦♦♦
Contraceptive Care - Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 3 Days	Administrative	37	2	5.41%	♦♦♦
Contraceptive Care - Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 60 Days	Administrative	37	5	13.51%	♦
Contraceptive Care - Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 3 Days	Administrative	37	2	5.41%	♦
Contraceptive Care - Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 60 Days	Administrative	37	15	40.54%	♦
Dental Sealants for 6-9 Year Old Children at Elevated Risk	Administrative	1,118	265	23.70%	♦
Follow-Up After Hospitalization for Mental Illness: 7 Days Follow-Up - Ages 6-7	Administrative	288	165	57.29%	♦♦♦
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up - Ages 6-7	Administrative	288	216	75.00%	♦♦
Percentage of Eligible (Children) that Received Preventive Dental Services	Administrative	20,061	10,085	50.27%	♦♦♦

Performance Measure	Data Collection Method*	Eligible Population	Numerator	ABHWV MY 2020 Rate	Comparison to Benchmarks~
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Hybrid	22	19	86.36%#	♦♦

* Administrative data collection: rates are calculated using claims and other supplemental data. Hybrid data collection: rates are calculated using administrative and medical record data.
~ Benchmark data source: Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set Chart Pack, November 2021
# Caution should be used when interpreting rates based on small denominators. A denominator less than 30 is considered small.

Conclusion

Aggregate summary conclusions for the PMV activity are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 48-51 within the MCP Quality, Access, Timeliness Assessment section, later in the report.

- All MCPs had information systems capable of capturing and processing data required for reporting.
- The MHT and MHP MCPs all received overall PMV ratings of 100%, providing high confidence in MCP measure calculations and reporting.
- An analysis of PMs with benchmarks demonstrates MY 2020 MHT MCP weighted averages met or exceeded national average benchmarks in 18 of 35 (51%) measures. The following 6 measures demonstrated commendable performance and met or exceeded the 75th percentile benchmarks:
    - Contraceptive Care - All Women Ages 15-20 Most or Moderately Effective Method of Contraception
    - Contraceptive Care - Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception, 3 Days
    - Dental Sealants for 6-9 Year Old Children at Elevated Risk
    - Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up
    - PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
    - PQI 15: Asthma in Younger Adults Admission Rate
- The MY 2020 MHP ABHWV rates met or exceeded national average benchmarks in 6 of 10 (60%) measures. The following 4 measures demonstrated commendable performance and met or exceeded the 75th percentile benchmarks:
    - Ambulatory Care: Emergency Department Visits – 0-19 Years (Visits per 1,000 Member Months)
    - Contraceptive Care - Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 3 Days
    - Follow-Up After Hospitalization for Mental Illness - Ages 6-7: 7 Days Follow-Up
    - Percentage of Eligible (Children) that Received Preventative Dental Services

Systems Performance Review

Objective

SPRs, also referred to as compliance reviews in the CFR, assess MCP compliance with structural and operational standards, which may impact the quality, timeliness, or accessibility of health care services provided to managed care members. The comprehensive review determines compliance with federal and state managed care program requirements. The SPR provides BMS an independent assessment of MCP capabilities, which can be used to promote accountability and improve quality-related processes and monitoring.

Methodology

Qlarant conducts a comprehensive review of applicable managed care standards, within a three-year period, in compliance with 42 CFR §438.358(b)(iii). Qlarant reviews the following 42 CFR §438 standards:

- Subpart A §438.10: Information Requirements
- Subpart B §438.56: Disenrollment Requirements and Limitations
- Subpart C §438.100 - §438.114: Enrollee Rights and Protections
- Subpart D §438.206 - §438.242: MCO Standards
- Subpart E §438.330: Quality Assessment and Performance Improvement Program
- Subpart F §438.402 - §438.424: Grievance and Appeal System
- Subpart H §438.608: Program Integrity Requirements Under the Contract

Table 36 identifies the three-year review schedule Qlarant follows for the SPR.

Table 36. Three-Year SPR Schedule

Standard	Year 1	Year 2	Year 3
§438.10 Information Requirements			✓
§438.56 Disenrollment Requirements and Limitations			✓
§438.100 - §438.114 Enrollee Rights and Protections			✓
§438.206 - §438.242 MCO Standards	✓		
§438.330 Quality Assessment and Performance Improvement Program		✓	
§438.402 - §438.424 Grievance and Appeal System		✓	
§438.608 Program Integrity Requirements Under the Contract	✓		

Description of Data Obtained. MCPs provided documentation to support 2020 compliance with MCO Standards and Program Integrity Requirements Under the Contract (Year 1 standards), in January 2021. Supporting data was obtained during all three phases of review: pre-onsite visit, onsite visit, and post-onsite visit. Qlarant review activities occurred before, during, and after the virtual ("onsite") visit to the MCP in March 2021. Pre-onsite visit activities included evaluating policies, reports, meeting minutes, and other supporting documents submitted by the MCP. Onsite visit activities focused on MCP staff interviews, process demonstrations, and record reviews. Post-onsite visit activities included an opportunity for the MCP to respond to preliminary findings and provide additional evidence of compliance, if available.

Technical Methods of Data Collection and Analysis. The 2021 SPR, which evaluated MY 2020 compliance, was conducted in a manner consistent with *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations.*[14] Qlarant conducted an interactive review with the MCP and reviewed and scored all applicable elements and components of each standard requiring evaluation. Qlarant uses the following scale when evaluating MCP compliance for each element and/or component:

- **Met.** Demonstrates full compliance. 1 point. Documentation and data sources provide evidence of compliance and MCP staff are able to describe processes consistent with documentation provided, if applicable.
- **Partially Met.** Demonstrates at least some, but not full, compliance. 0.5 point. Documentation is present, but staff are unable to articulate processes or show evidence of implementation during interviews; or staff are able to describe and verify the existence of processes, but documentation is incomplete or inconsistent with practice.
- **Not Met.** Does not demonstrate compliance on any level. 0 points. Documentation and data sources are not present or do not provide evidence of compliance, and staff are unable to describe and/or verify the existence of processes required to demonstrate compliance.
- **Not Applicable.** Requirement does not apply and is not scored.

Aggregate points earned are reported by standard and receive a compliance score based on the percentage of points earned. All assessments are weighted equally, which allows standards with more elements and components to have more influence on a final score. Finally, an overall SPR compliance score is calculated. Based on this overall score, a level of confidence in the MCP's SPR results is determined. Compliance ratings include:

- ❖ 95% - 100%: high confidence in MCP compliance
- ❖ 85% - 94%: moderate confidence in MCP compliance
- ❖ 75% - 84%: low confidence in MCP compliance
- ❖ ≤74%: no confidence in MCP compliance

Results

MHT Systems Performance Review Results

Table 37 displays 2021 MHT MCP SPR results by standard and identifies an overall weighted score. A level of confidence in each MCP's compliance is assigned based on their overall weighted score. The table also includes MCP averages.

Table 37. 2021 MHT MCP SPR Results (MY 2020 Compliance)

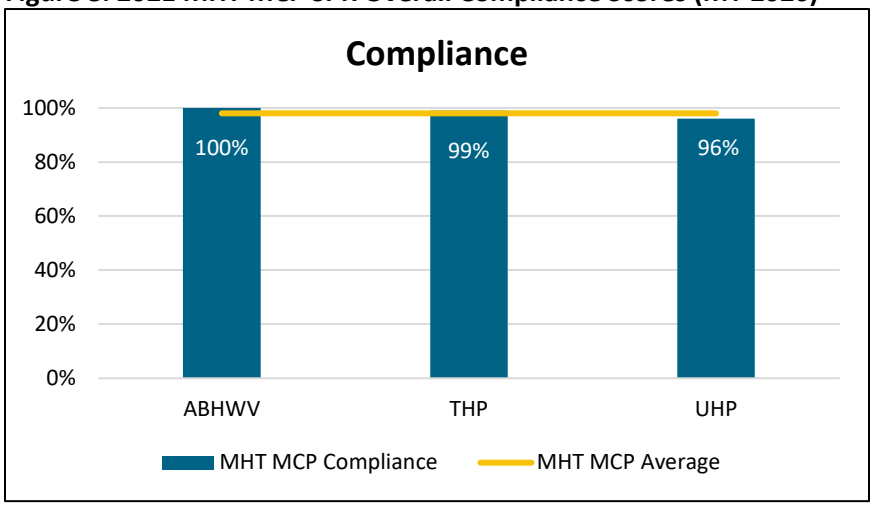
Standard	ABHWV	THP	UHP	MHT MCP AVG
§438.206 - §438.242 MCO Standards (See Table 39 for additional substandard detail)	100%	99%	96%	98%
§438.608 Program Integrity Requirements Under the Contract	100%	100%	100%	100%
Overall Weighted Score	100%	99%	96%	98%

[14] CMS EQRO Protocols

Standard	ABHWV	THP	UHP	MHT MCP AVG
Level of Confidence	High Confidence ❖	High Confidence ❖	High Confidence ❖	High Confidence ❖

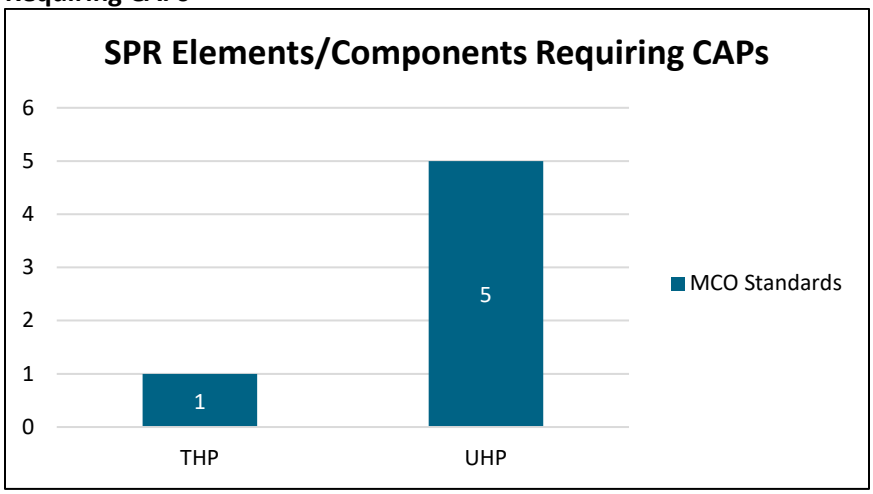
Figure 8 illustrates 2021 MHT MCP SPR scores including the MHT MCP weighted average of 98%.

Figure 8. 2021 MHT MCP SPR Overall Compliance Scores (MY 2020)



ABHWV scored 100% compliance in the 2021 SPR. THP and UHP had overall scores of 99% and 96%, respectively. In response to these results, THP and UHP were required to develop corrective action plans (CAPs) for the elements/components not meeting full compliance. THP was required to develop one CAP, while UHP was required to develop five CAPs. All required CAPs were for noncompliance in the MCO Standards, as the MCPs demonstrated 100% compliance in the Program Integrity Requirements Under the Contract Standard. Figure 9 identifies the number of elements/components in which an MCP CAP was required.

Figure 9. 2021 MHT MCP SPR Elements/Components by Standard Requiring CAPs



THP and UHP developed and completed CAPs, as required. Qlarant and BMS approved the CAPs and Qlarant monitored them quarterly until each CAP was closed. Figure 10 illustrates all CAPs were closed or resolved during 2021.

Figure 10. 2021 MHT MCP SPR CAP Status

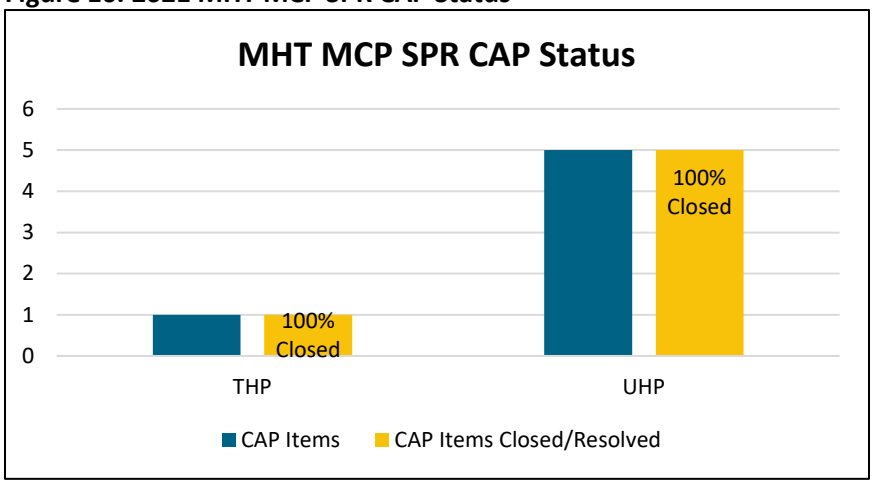


Table 38 includes MHT MCP SPR results of all standards within the last three-year review period.

Table 38. MHT MCP SPR Results of All Standards Within the Last Three Years

Standard	Year Reviewed	ABHWV	THP	UHP	MHT MCP AVG
§438.10 Information Requirements	2020	100%	100%	100%	100%
§438.56 Disenrollment Requirements and Limitations*	2021	100%	100%	100%	100%
§438.100 - §438.114 Enrollee Rights and Protections*	2021	100%	100%	100%	100%
§438.206 - §438.242 MCO Standards (see Table 39 for additional substandard detail)	2021	100%	99%	96%	98%
§438.330 Quality Assessment and Performance Improvement Program	2020	100%	100%	93%	98%
§438.402 - §438.424 Grievance and Appeal System	2019	100%	95%	92%	96%
§438.608 Program Integrity Requirements Under the Contract	2021	100%	100%	100%	100%

*New requirements were added and a baseline review was conducted in a desktop audit separate from the 2021 annual SPR. These standards will be reviewed again in 2023.

Table 39 details MHT MCP results of the MCO Standards (§438.206 - §438.242) from the 2021 SPR. Performance for each area of review is reported as met, partially met, or not met.

- **Met.** All elements and components for the standard were fully met.
- **Partially Met.** Some, but not all, elements and components for the standard were met.
- **Not Met.** None of the elements and components for the standard were met.

Table 39. §438.206 - §438.242 MCO Standards – 2021 MHT MCP SPR Results (MY 2020 Compliance)

MCO Standards	ABHWV	THP	UHP
438.206 Availability of Services	Met	Partially Met	Partially Met
438.207 Assurances of Adequate Capacity and Services	Met	Met	Partially Met
438.208 Coordination and Continuity of Care	Met	Met	Partially Met
438.210 Coverage and Authorization of Services	Met	Met	Met
438.214 Provider Selection	Met	Met	Met
438.224 Confidentiality	Met	Met	Met
438.228 Grievance and Appeal Systems	Standard reviewed separately in 2019*		
438.230 Subcontractual Relationships and Delegation	Met	Met	Met
438.236 Practice Guidelines	Met	Met	Met
438.242 Health Information Systems[+]	Met	Met	Met

* See Table 38 for MHT MCP Grievance and Appeal System Standard results.
[+] MCP Health Information Systems were evaluated as part of the PMV activity.

MHP Systems Performance Review Results

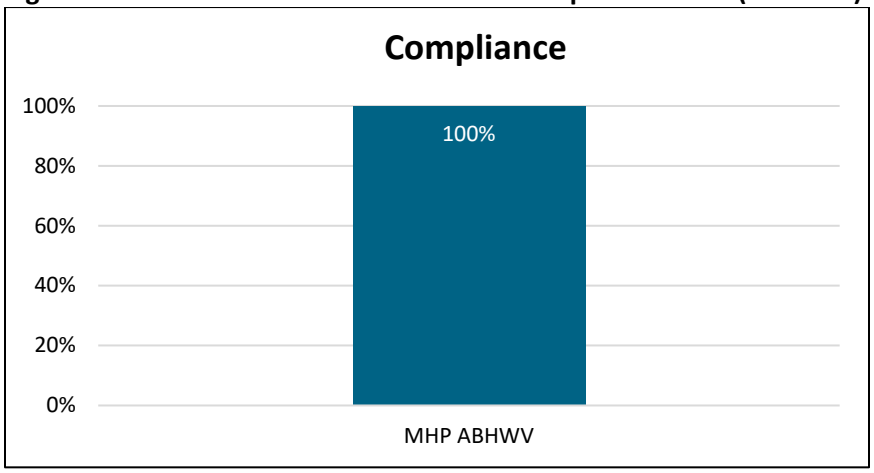
The 2021 SPR was the first annual review conducted for the MHP program. Table 40 displays 2021 MHP ABHWV SPR results by standard and identifies an overall weighted score. A level of confidence is assigned based on ABHWV's overall weighted score.

Table 40. 2021 MHP ABHWV SPR Results (MY 2020 Compliance)

Standard	MHP ABHWV
§438.206 - §438.242 MCO Standards	100%
§438.608 Program Integrity Requirements Under the Contract	100%
Overall Weighted Score	100%
Level of Confidence	High Confidence ❖

Figure 11 illustrates the 2021 MHP ABHWV SPR overall weighted score of 100%.

Figure 11. 2021 MHP ABHWV SPR Overall Compliance Score (MY 2020)



Since ABHWV achieved 100% compliance, CAPs were not required.

Table 41 includes MHP ABHWV SPR results of the standards reviewed in the 2021 SPR—its first annual review. The table also identifies when standards will be reviewed in the next two years, ensuring a comprehensive review in the three-year cycle.

Table 41. MHP ABHWV SPR Results of All Standards

Standard	Year Reviewed or Scheduled to be Reviewed➢	MHP ABHWV
§438.10 Information Requirements	2023	Not Reviewed Yet
§438.56 Disenrollment Requirements and Limitations*	2021	100%
§438.100 - §438.114 Enrollee Rights and Protections*	2021	100%
§438.206 - §438.242 MCO Standards (see Table 42 for additional detail)	2021	100%
§438.330 Quality Assessment and Performance Improvement Program	2022	Not Reviewed Yet
§438.402 - §438.424 Grievance and Appeal System	2022	Not Reviewed Yet
§438.608 Program Integrity Requirements Under the Contract	2021	100%

➢The MHP program was implemented March 1, 2020. The 2021 SPR was the MCP's first review (for MY 2020). All standards will be reviewed within the three-year cycle to ensure compliance with 42 CFR §438.358(b)(iii).
*New requirements were added and a baseline review was conducted in a desktop audit separate from the 2021 annual SPR. These standards will be reviewed again in 2023.

Table 42 details the results of the MCO Standards (§438.206 - §438.242) from the 2021 SPR. Performance for each area of review is reported as met, partially met, or not met.

Table 42. §438.206 - §438.242 MCO Standards – 2021 MHP ABHWV SPR Results (MY 2020 Compliance)

MCO Standards	ABHWV
438.206 Availability of Services	Met
438.207 Assurances of Adequate Capacity and Services	Met
438.208 Coordination and Continuity of Care	Met
438.210 Coverage and Authorization of Services	Met
438.214 Provider Selection	Met
438.224 Confidentiality	Met
438.228 Grievance and Appeal Systems	Standard will be reviewed separately in 2022*
438.230 Subcontractual Relationships and Delegation	Met
438.236 Practice Guidelines	Met
438.242 Health Information Systems+	Met

* The full Grievance and Appeal System Standard (§438.402 - §438.424) will be reviewed in 2022.
+ MCP Health Information Systems were evaluated as part of the PMV activity.

Conclusion

Summary conclusions for the SPR activity are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 48-51 within the MCP Quality, Access, Timeliness Assessment section, later in the report.

- The MHT MCPs received overall weighted scores ranging from 96%-100% for the 2021 SPR, which evaluated MY 2020 compliance with MCO Standards and Program Integrity Requirements

Under the Contract. The MHT MCP average was 98%. Stakeholders can have high confidence in the MHT MCPs' level of compliance.
- THP and UHP effectively developed and completed CAPs based on 2021 SPR findings. These CAPs are detailed in the MCP Quality, Access, Timeliness Assessment section.
- The first annual SPR was conducted for the MHP MCP, ABHWV. The MCP achieved 100% compliance in the standards reviewed, yielding high confidence in its level of compliance.

Network Adequacy Validation

Objective

NAV evaluates whether MCPs are maintaining adequate provider networks and meeting availability service requirements. The Code of Federal Regulations, 42 CFR §438.206 - Availability of Services, requires MCPs to make services included in its contract available 24 hours a day, 7 days a week (24/7), when medically necessary. If providers are not readily available after regular business hours, they should have a process in place to direct members to care. NAV results provide BMS and other stakeholders with a level of confidence in provider compliance with the 24/7 requirement including directing members to care during nonbusiness hours.

Methodology

Qlarant conducted quarterly telephone surveys to complete the NAV activity, which evaluated MY 2021 compliance.

Description of Data Obtained. MCPs submitted their up-to-date provider directories, in an electronic file, to Qlarant on a quarterly basis. MCPs submitted provider name, specialty, practice name, address, phone number, and other requested demographic information.

Technical Methods of Data Collection and Analysis. Qlarant completed quarterly validation activities by randomly selecting and surveying a sample of providers from each MCP's provider directory. For the MHT program, Qlarant surveyed a mix of PCPs providing services to all members and PCPs providing services to children. For the MHP program, Qlarant surveyed a mix of PCPs and behavioral health providers serving children. Qlarant surveyors called each provider office after business hours and/or on weekends to determine provider compliance with the access standard. Information collected during telephone surveys evaluated the accessibility of each MCP's network of providers and instructions given to members after the provider offices closed for the day.

Compliance is assessed as meeting one of the following criteria. Calls are answered by a(n):

- Live person employed by the practice who provided guidance to the caller seeking care
- Answering service (live person provided guidance to the caller seeking care)
- On-call provider who provided guidance to the caller seeking care
- Recorded or automated message which provided instruction to go to the nearest emergency room or call 911 for an emergency situation, call a nurse line, or similar instruction on how to obtain care

Results

MHT Network Adequacy Validation Results

Table 43 includes the percentage of 2021 provider surveys resulting in successful contact for each MHT MCP. Surveys were deemed successful if contact was made with a live person, answering service, on-call provider, or recorded/automated message. MCP performance ranged from 83% to 91% for MY 2021.

Table 43. Successful Contact Per MHT MCP for MY 2021

MY 2021 NAV	ABHWV	THP	UHP	MHT MCP AVG
Successful Contact	83%	91%	86%	87%

Figure 12 illustrates the percentage of provider surveys that resulted in successful contact for MY 2021. MHT MCP results are compared to the MHT MCP average, 87%.

Figure 12. Successful Contact Per MHT MCP for MY 2021

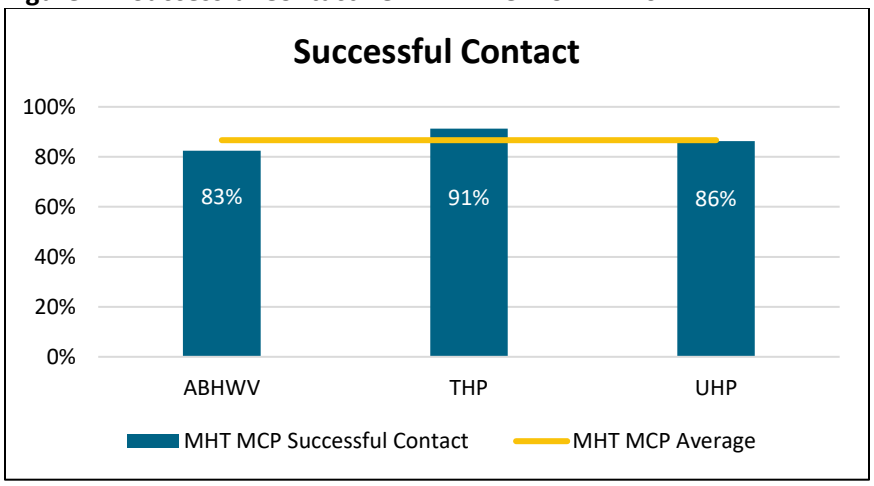
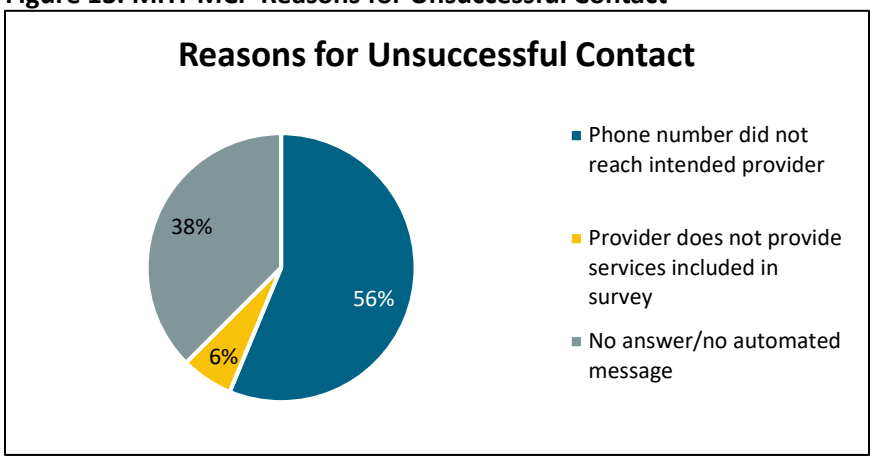


Figure 13 displays reasons, in aggregate, for unsuccessful contact. Most unsuccessful surveys (56%) were due to the phone number not reaching the intended provider. This was followed by no answer/no automated message (38%) and provider does not provide services included in the survey (6%).

Figure 13. MHT MCP Reasons for Unsuccessful Contact



For each successful contact, Qlarant evaluated the provider's compliance with the 24/7 access requirement. Table 44 reports each MHT MCP's rate of provider compliance, which ranged from 94% to 100%, for MY 2021.

Table 44. MHT MCP Provider Compliance with 24/7 Access Requirements for MY 2021

MY 2021 NAV	ABHWV	THP	UHP	MHT MCP AVG
Compliance with 24/7 Access Requirements	94%	97%	100%	97%

Figure 14 displays 2021 MHT MCP provider compliance with 24/7 access requirements compared to the MHT MCP average, 97%.

Figure 14. MHT MCP Provider Compliance with 24/7 Access Requirements for MY 2021

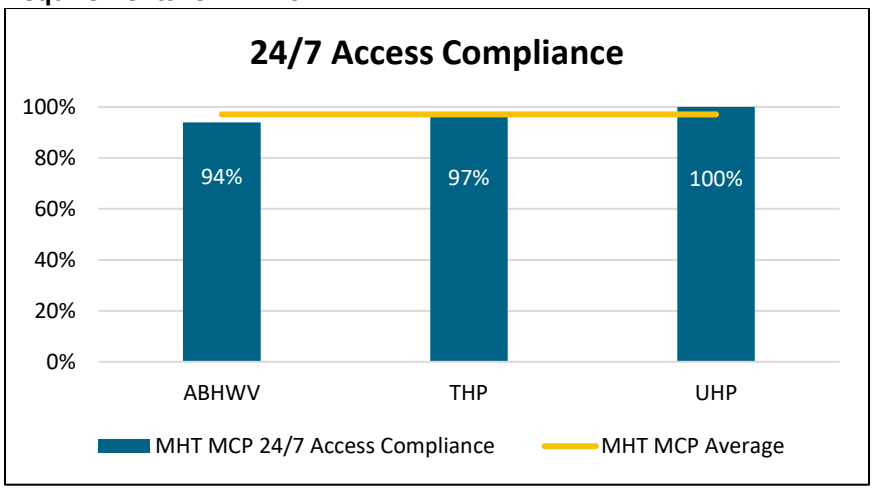


Figure 15 displays reasons, in aggregate, for MY 2021 noncompliance. All occurrences of noncompliance were due to a recorded/automated message not directing the member to care.

Figure 15. MHT MCP Reasons for Noncompliance

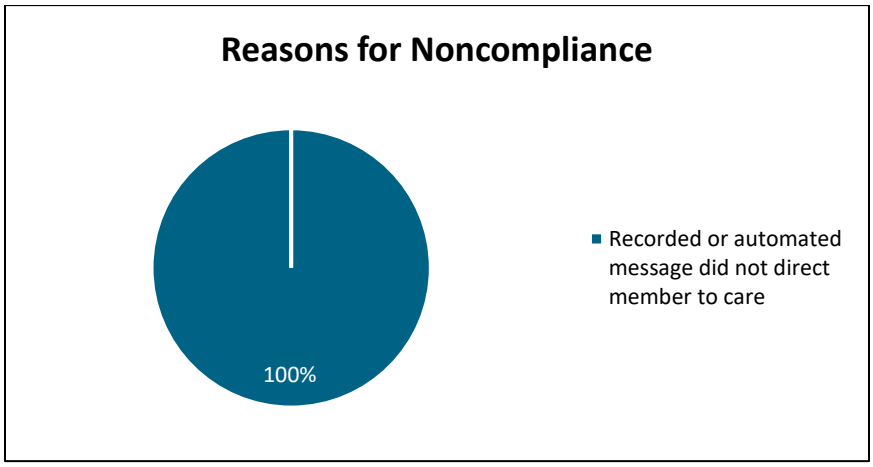


Figure 16 compares annual MHT MCP successful contact performance for the two years, since the 2020 study implementation. All MHT MCPs demonstrated improvement and the average increased from 83% to 87%.

Figure 16. MHT MCP Successful Contact for MYs 2020 and 2021

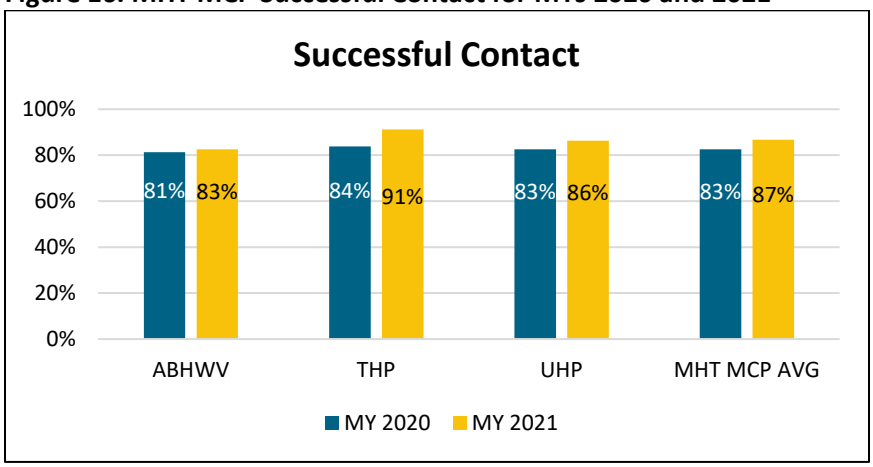
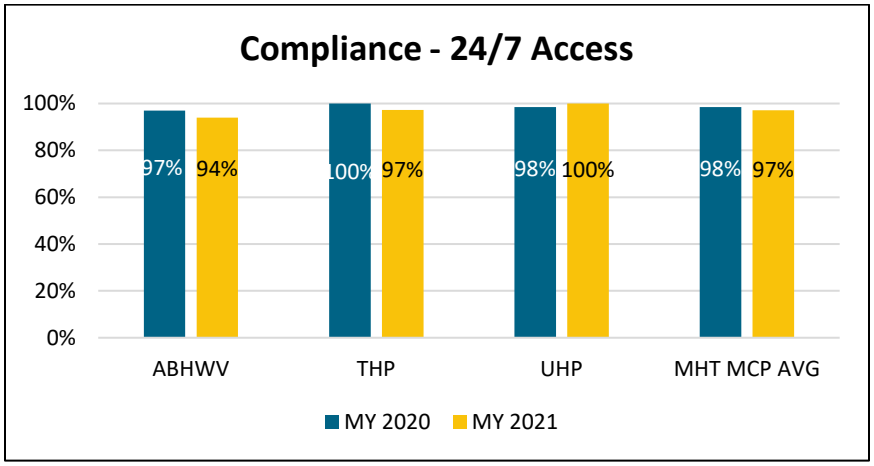


Figure 17 compares annual MHT MCP compliance with the 24/7 access requirement. Only UHP improved performance. The MHT MCP average experienced a marginal decline from 98% to 97%.

Figure 17. MHT MCP Compliance with 24/7 Access Requirement for MYs 2020 and 2021



MHP Network Adequacy Validation Results

Figure 18 displays the percentage of MY 2021 MHP ABHWV provider surveys resulting in successful contact, 76%.

Figure 18. MHP ABHWV Successful Contact for MY 2021

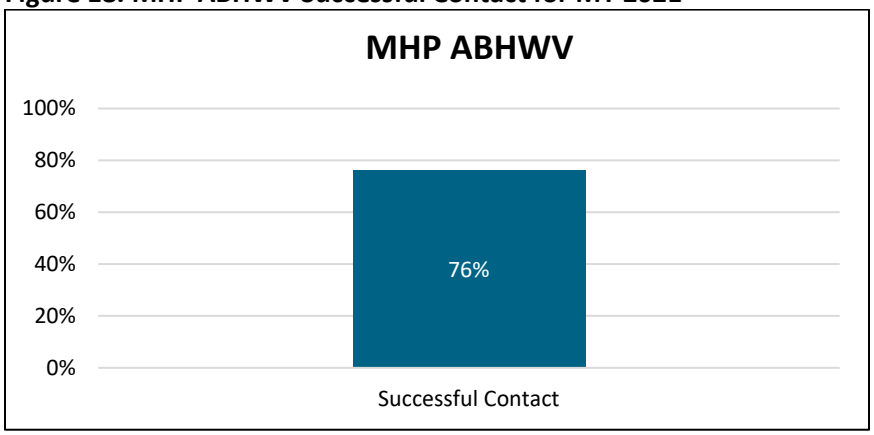


Figure 19 illustrates reasons for unsuccessful contact. Similar to the MHT survey findings, most MHP ABHWV unsuccessful surveys were due to the phone number not reaching the intended provider (68%). This was followed by no answer/no automated message (26%) and live answer, but refusal to participate in the survey (5%).[15]

[15] Rates total 99%, rather than 100%, due to rounding.

Figure 19. Reasons for Unsuccessful Contact

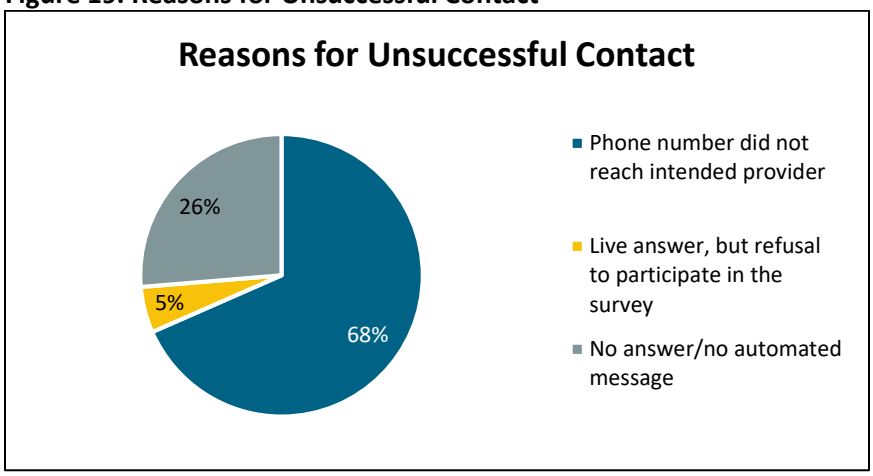
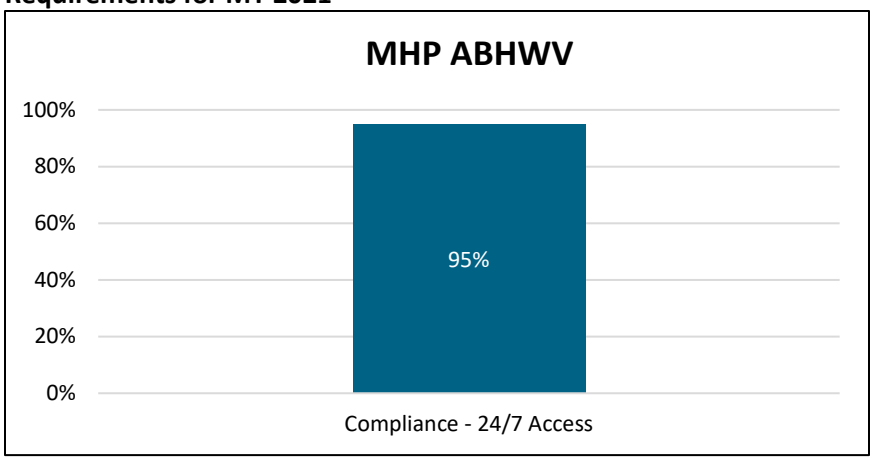


Figure 20 displays the MY 2021 MHP ABHWV level of provider compliance with the 24/7 access requirement, 95%.

Figure 20. MHP ABHWV Provider Compliance with 24/7 Access Requirements for MY 2021



Consistent with the MHT MCP findings, all MHP ABHWV provider noncompliance was due to a recorded/automated message not directing the member to care. This finding is displayed in Figure 21.

Figure 21. MHP ABHWV Reasons for Noncompliance

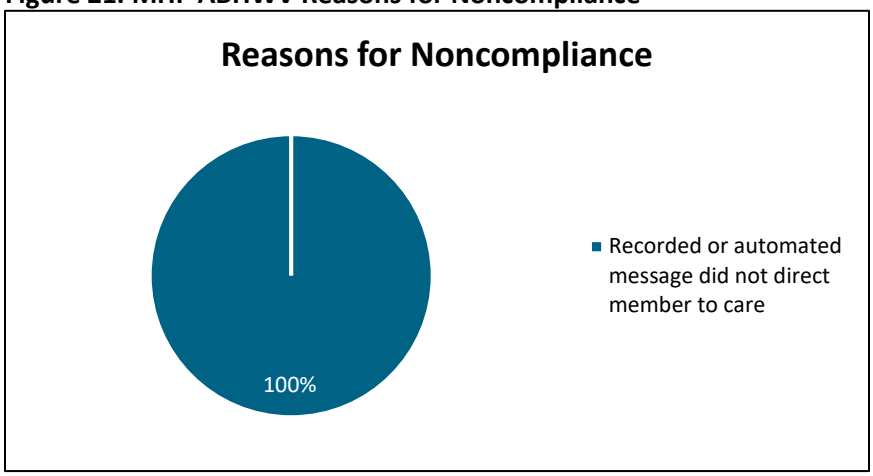


Figure 22 compares annual MHP ABHWV successful contact performance for the two years since the study implementation in 2020. Successful contact declined from 83% to 76%.

Figure 22. MHP ABHWV Successful Contact for MYs 2020 and 2021

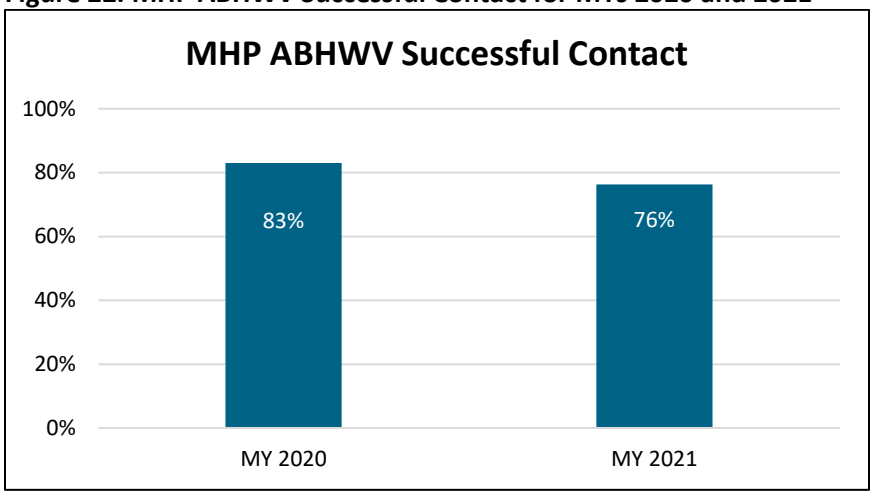
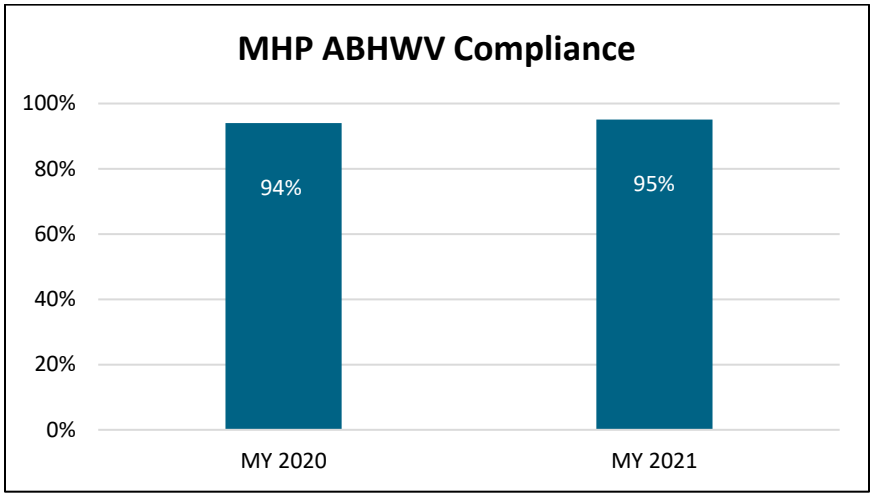


Figure 23 compares annual MHP ABHWV compliance with the 24/7 access requirement. The MHP MCP demonstrated marginal improvement from 94% to 95%.

Figure 23. MHP ABHWV Compliance with 24/7 Access Requirement for MYs 2020 and 2021



Conclusion

Qlarant conducted quarterly surveys evaluating provider compliance with 24/7 access requirements. Aggregate summary conclusions for the NAV activity are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 48-51 within the MCP Quality, Access, Timeliness Assessment section, later in the report.

- The MY 2021 MHT MCP average rate for successful contact with the intended provider was 87%, a four percentage point increase from the MY 2020 average. MHT MCP performance ranged from 83%-91%. Most unsuccessful contacts, 56%, were due to the phone number not reaching the intended provider.
- The MY 2021 MHT MCP average rate for provider compliance with the 24/7 access requirement was 97%, a marginal decline from the MY 2020 average of 98%. MHT MCP performance ranged from 94%-100%. Noncompliance, in all instances, was attributed to the provider not having a recorded/automated message directing the member to care.
- The MY 2021 MHP ABHWV rate for successful contact with the intended provider was 76%, a seven percentage point decline from the MY 2020 rate, 83%. The majority of unsuccessful contacts, 68%, were attributed to the phone number not reaching the intended provider.
- The MY 2021 MHP ABHWV rate for provider compliance with 24/7 access requirements was 95%, a one percentage point improvement from the MY 2020 rate of 94%. All instances of noncompliance were due to the provider not having a recorded/automated message directing the member to care.

Encounter Data Validation

Objective

States rely on valid and reliable encounter/claims data submitted by MCPs to make key decisions.[16] For example, states may use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates. As payment methodologies evolve and incorporate value-based payment elements, collecting complete and accurate encounter data is critical. Results of the EDV study provide BMS with a level of confidence in the completeness and accuracy of encounter data submitted by the MCPs.

Methodology

Qlarant's 2021 EDV activities focused an evaluation of provider office encounters including claims paid during MY 2020.

Description of Data Obtained. Qlarant obtained the following data to complete the EDV study:

- Claims data from BMS's fiscal agent, which included provider office claims paid January 1, 2020 through December 31, 2020
- Information Systems Capabilities Assessment documentation from the MCPs
- Medical records from providers

Technical Methods of Data Collection and Analysis. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*.[17] To assess the completeness and accuracy of MCP encounter data, Qlarant completed the following activities:

- Reviewed state requirements for collecting and submitting encounter data
- Reviewed each MCP's capability to produce accurate and complete encounter data, which included an evaluation of the MCP's Information Systems Capabilities Assessment and interviews with key MCP staff
- Analyzed MCP electronic encounter data for accuracy and completeness including an examination for consistency, accuracy, and completeness
- Reviewed medical records gathered from provider offices to confirm electronic encounter data accuracy

To complete the medical record reviews, Qlarant reviewers compared medical record documentation to electronic encounter data to confirm the accuracy of reported encounters. Specifically, reviewers evaluated the accuracy of diagnosis and procedure codes for the randomly selected encounters. When documentation supported the diagnosis and procedure codes for the encounter under review, results were assessed as matching. When documentation did not support the diagnosis or procedure codes, results were assessed as not matching (or deemed as "no match").

[16] Encounter data consists of claims; therefore, these terms, encounter data and claims, are used interchangeably in this report.
[17] CMS EQRO Protocols

Results

MHT Encounter Data Validation Results

Qlarant found all MHT MCPs had the capability to produce accurate and complete encounter data. Analysis of the electronic encounter data determined:

- The volume of encounters submitted was reasonable.
- Most claims were submitted on a timely basis.
- Required data fields contained complete and/or valid values.
- The use of diagnosis and procedure codes was appropriate according to members' age and/or gender.

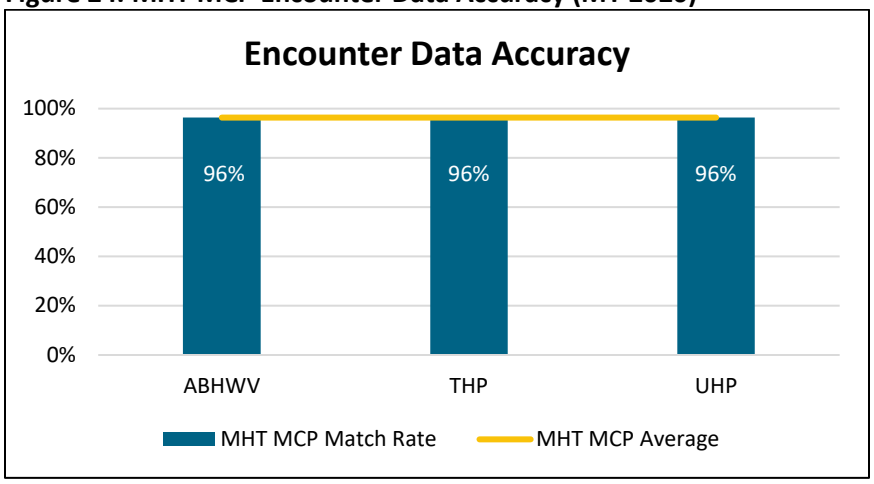
Qlarant's medical record review evaluated the accuracy of diagnoses and procedure codes in the electronic encounter data. Table 45 displays MHT MCP accuracy or "match rates." A match occurs when the electronic diagnosis and procedure codes are supported by medical record documentation. The 2021 medical record reviews, evaluating claims paid during MY 2020, confirmed high encounter data accuracy with all MCPs scoring 96%.

Table 45. MHT MCP Encounter Data Accuracy

MY 2020 MHT EDV	ABHWV	THP	UHP	MHT MCP AVG
Accuracy or Match Rate	96%	96%	96%	96%

Figure 24 illustrates MHT MCP encounter data accuracy compared to the average.

Figure 24. MHT MCP Encounter Data Accuracy (MY 2020)



Four percent of MHT MCP record elements reviewed resulted in a "no-match" finding. Figure 25 illustrates reasons for "no match" in diagnosis codes based on the medical record review activity, in aggregate. Most findings were due to a lack of documentation in the record (74%).

Figure 25. MHT MCP Reasons for "No Match" in Diagnosis Codes

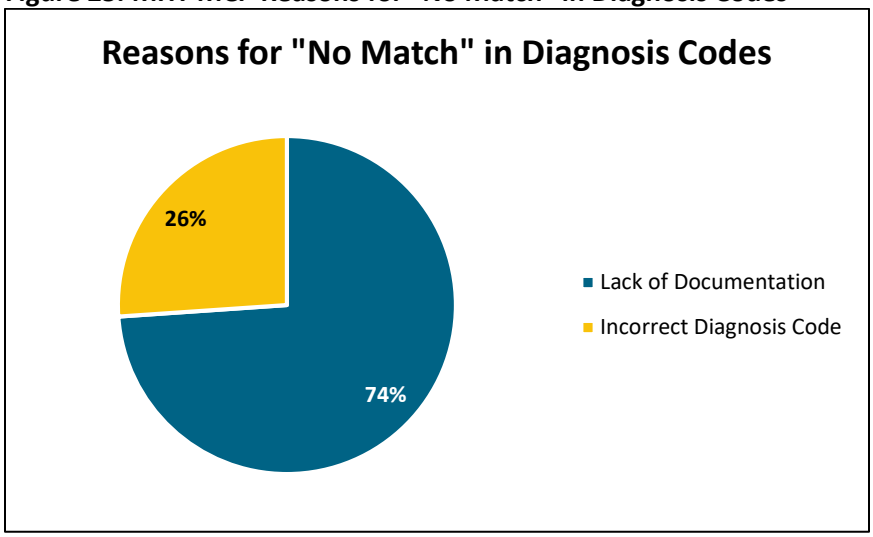


Figure 26 displays reasons for "no match" in procedure codes based on the MHT MCP medical record review activity. Most findings were due to a lack of documentation in the record (82%).

Figure 26. MHT MCP Reasons for "No Match" in Procedure Codes

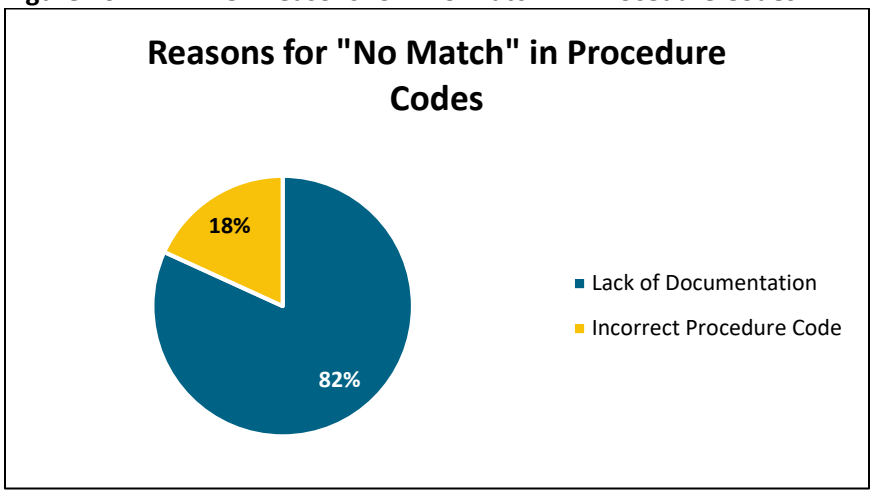
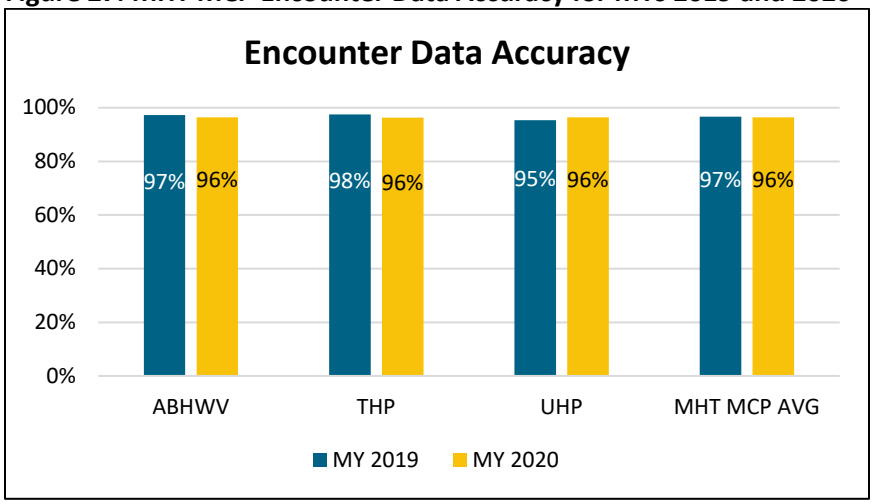


Figure 27 illustrates encounter data accuracy for the last two years since project implementation. Only UHP improved performance (95% to 96%). The MHT MCP average declined from 97% to 96%.

Figure 27. MHT MCP Encounter Data Accuracy for MYs 2019 and 2020



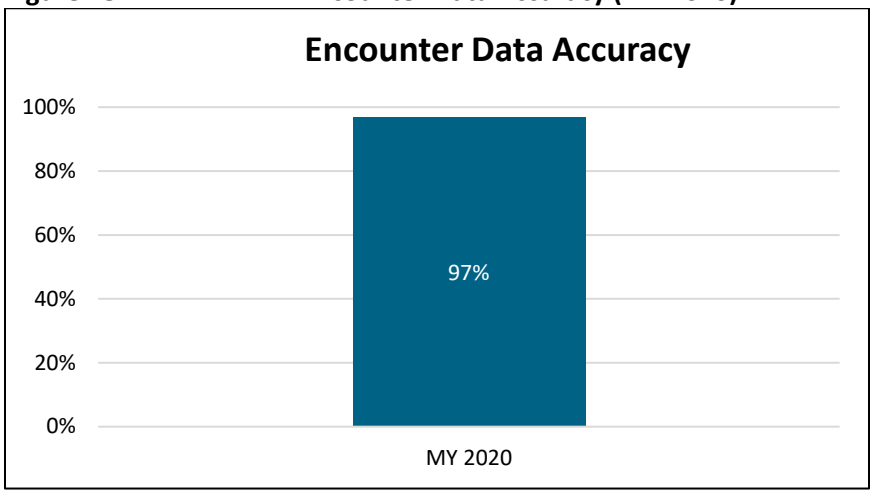
MHP Encounter Data Validation Results

Qlarant found MHP ABHWV had the capability to produce accurate and complete encounter data. Analysis of the electronic encounter data determined:

- The volume of encounters submitted was reasonable.
- Most claims were submitted on a timely basis.
- Required data fields contained complete and/or valid values.
- The use of diagnosis and procedure codes was appropriate according to members' age and/or gender.

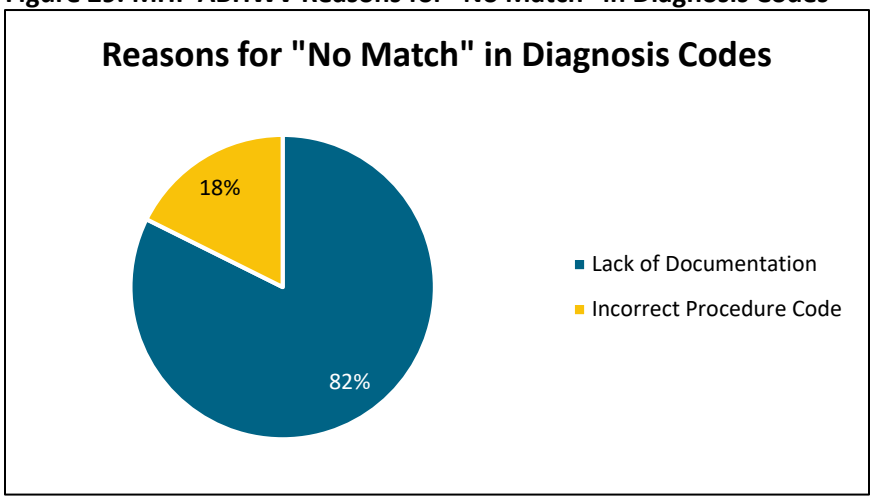
Figure 28 displays the MHP ABHWV accuracy or "match rate." The 2021 medical record reviews, evaluating claims paid during MY 2020 (March 1, 2020, through December 31, 2020, due to the March 1, 2020 program implementation), confirmed a high encounter data accuracy of 97%.

Figure 28. MHP ABHWV Encounter Data Accuracy (MY 2020)



All “no match” elements resulted from the diagnosis code review. All procedure code elements matched. Figure 29 displays MHP ABHWV’s principle reasons for “no match” in diagnosis code elements. Most findings were due to a lack of documentation in the record (82%).

Figure 29. MHP ABHWV Reasons for “No Match” in Diagnosis Codes



No comparison results are available for trending as this EQR activity commenced in 2021 for the MHP program.

Conclusion

Aggregate summary conclusions for the EDV activity are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 48-51 within the MCP Quality, Access, Timeliness Assessment section, later in the report.

- An evaluation of each MCP’s Information Systems Capabilities Assessment determined all MCPs had the capability to produce accurate and complete encounter data for MY 2020.
- Analysis of provider office claims paid in MY 2020 confirmed reasonable encounter volume, timely submission, complete and/or valid values, and appropriate usage of codes for all MCPs.
- A medical record review determined a high level of encounter data accuracy. All MHT MCPs achieved 96% encounter data accuracy in MY 2020. The MY 2020 MHT MCP average match rate declined by one percentage point compared to MY 2019’s rate of 97%.
- The first EDV audit for MHP ABHWV also resulted in a high level of encounter data accuracy assessment, 97%.

Grievance, Denial, and Appeal Focused Study

Objective

MCP members have the right to file a grievance when they are not satisfied with care or services and the right to file a request to appeal when they do not agree with a decision made by the MCP. The MCPs must follow federal and state requirements when:

- Responding to a member grievance
- Making a decision to deny, reduce, or terminate a member service or benefit (adverse determination)
- Reviewing a member appeal and upholding or overturning a decision to deny, reduce, or terminate a service or benefit

Qlarant conducts a focused study by collecting information on MCP grievances, denials, and appeals; completing random sample record reviews, and evaluating MCP compliance with federal and state requirements. The focused study and validation activities provides BMS with a level of confidence in MCP procedures and compliance with requirements.

Methodology

Qlarant's 2021 focused study activities focused an evaluation of grievances, denials, and appeals received during MY 2020.

Description of Data Obtained. MCPs submitted their grievance, denial, and appeal "universes" to Qlarant on a quarterly basis. Qlarant collected all information and selected random sample records for each category. MCPs were notified of the selected sample and provided complete grievance, denial, and appeal records to Qlarant for review and validation activities.

Technical Methods of Data Collection and Analysis. Qlarant examined records and evaluated MCP compliance with federal and state requirements. Grievance records were evaluated to ensure the MCP provided a timely acknowledgment and resolution notification. Denials, or adverse determination records, were reviewed to assess compliance with timely notification of decisions and required letter content such as communication of a member's right to file an appeal and procedures on how to do so. Appeal records were evaluated to ensure the MCP provided timely member acknowledgment and resolution notification and required letter content such as communication of a member's right to request a state fair hearing and procedures on how to make such request.

This focused study, implemented in 2020, is a new task and previous annual results are not available.

Results

Table 46 includes MHT MCP grievance, denial, and appeal compliance results for MY 2020. Annual results, based on an average of quarterly results, are displayed by MHT MCP. An MHT MCP average is also provided for each category.

- **Grievances.** MHT MCP performance ranged from 87% to 100%, with an average of 96%.
- **Denials.** MHT MCP performance ranged from 98% to 99%, with an average of 98%.
- **Appeals.** MHT MCP performance ranged from 95% to 100%, with an average of 98%.

Table 46. MHT MCP Grievance, Denial, and Appeal Compliance (MY 2020)

MY 2020 Compliance	ABHWV Compliance	THP Compliance	UHP Compliance	MHT MCP AVG Compliance
Grievances	87%	100%	100%	96%
Denials	99%	98%	98%	98%
Appeals	100%	99%	95%	98%

Figure 30 graphically displays MHT MCP MY 2020 results for the grievance, denial, and appeal focused study.

Figure 30. MHT MCP Grievance, Denial, and Appeal Compliance (MY 2020)

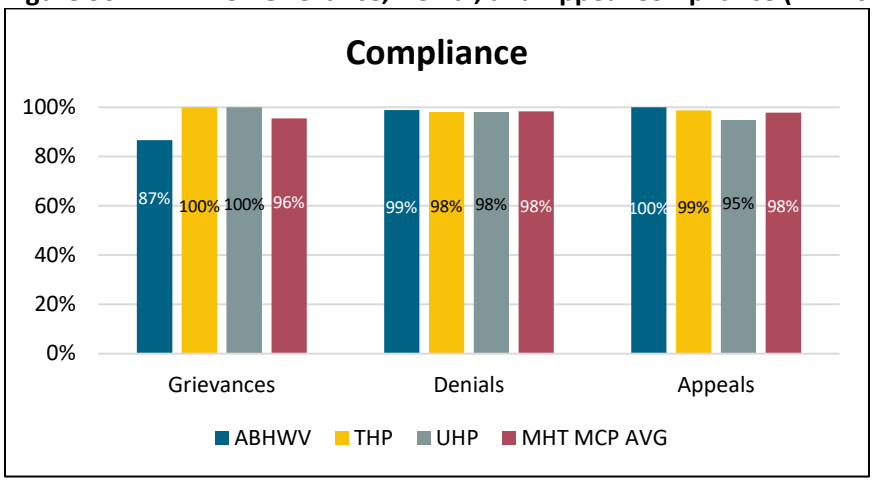


Table 47 includes MHP ABHWV grievance, denial, and appeal compliance results for MY 2020. ABHWV experienced a low grievance volume and received only five grievances for the year; caution is advised when interpreting results based on small numbers. MHP ABHWV demonstrated the following compliance rates:

- **Grievances.** MHP ABHWV compliance: 67%.
- **Denials.** MHP ABHWV compliance: 100%.
- **Appeals.** MHP ABHWV compliance: 100%.

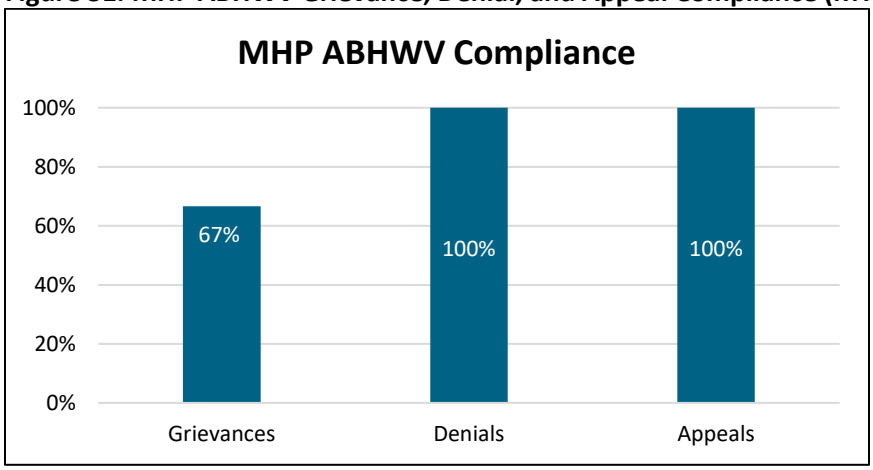
Table 47. MHP ABHWV Grievance, Denial, and Appeal Compliance (MY 2020)

MY 2020 Compliance	MHP ABHWV Compliance
Grievances	67%^
Denials	100%
Appeals	100%

^ ABHWV received a total of five grievances for 2020. Caution is advised when interpreting results based on small numbers.

Figure 31 graphically displays MHP ABHWV MY 2020 results for the grievance, denial, and appeal focused study. Again, caution is advised when interpreting MHP ABHWV's grievance compliance rate, which is based on five grievances received during MY 2020.

Figure 31. MHP ABHWV Grievance, Denial, and Appeal Compliance (MY 2020)



ABHWV received a total of five grievances for 2020. Caution is advised when interpreting results based on small numbers.

Conclusion

Aggregate summary conclusions for the focused study are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 48-51 within the MCP Quality, Access, Timeliness Assessment section, later in the report.

This focused study was implemented in 2020. Comparison results will not be available until the next annual report. MY 2020 MHT MCP averages demonstrated a high level of compliance, which include: grievances, 96%; denials, 98%; and appeals, 98%. Individual MHT MCP performance varied:

- MCP grievance compliance scores had the most variation and ranged from 87% to 100%.
- MCP denial compliance scores ranged from 98% to 99%.
- MCP appeal compliance scores ranged from 95% to 100%.

MHP ABHWV's performance ranged from a low compliance rating for grievances (67%) to fully compliant ratings for denials and appeals (100%). Caution is advised when interpreting ABHWV's grievance compliance rate, as the MCP only received five grievances for the year.

ABHWV's low grievance compliance ratings, for both MHT and MHP programs, was attributed to poor performance in quarter 1 2020. ABHWV remedied issues and demonstrated improvement in quarters 2-4 2020.

MCP Quality, Access, Timeliness Assessment

Quality, Access, Timeliness

Qlarant identified strengths and weaknesses for each MCP based on the results of the EQR activities. These strengths and weaknesses correspond to the quality, access, and timeliness of services provided to members. Qlarant adopted the following definitions for these domains:

Quality, as stated in the federal regulations as it pertains to EQR, is the degree to which an MCP "…increases the likelihood of desired outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidenced-based-knowledge, and (3) interventions for performance improvement." (CFR §438.320).

Access (or accessibility), as defined by NCQA, is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" *(NCQA Health Plan Standards and Guidelines*).

Timeliness, as stated by the Institute of Medicine is "reducing waits and sometimes harmful delays" and is interrelated with safety, efficiency, and patient-centeredness of care. Long waits in provider offices or emergency departments and long waits for test results may result in physical harm. For example, a delay in test results can cause delayed diagnosis or treatment—resulting in preventable complications.

Tables 48-51 highlight strengths and weaknesses for each MCP. Identified strengths and weaknesses correspond to the quality, access, and/or timeliness of services delivered to MCP members. Only applicable domains for each strength or weakness are identified with a (★) or (●) indicating a positive or negative impact as described below. Not all domains were impacted by each strength or weakness. Where appropriate, weaknesses include recommendations.

★ The MCP strength identified positively impacts quality, access, and/or timeliness.
● The MCP weakness identified negatively impacts quality, access, and/or timeliness.

Examples of the quality, access, and timeliness analysis include:

- If the MCP demonstrated full compliance in the Quality Assessment and Performance Improvement Program Standard, performance would be identified with a ★ in the quality domain.
- If the MCP did *not* provide female enrollees with direct access to a women's health specialist to provide routine and preventative health care services, performance would be identified with a ● in the access domain.
- If the MCP demonstrated statistically significant improvement in an Annual Dental Visits PIP measure, performance would be identified with a ★ in all three domains as the PIP is a quality project, which focuses on improving access to preventative dental care in a timely manner.

MHT ABHWV

Table 48. MHT ABHWV Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
MHT ABHWV - PERFORMANCE IMPROVEMENT PROJECT VALIDATION			
Annual Dental Visits PIP			
★	★	★	**Strength.** ABHWV received a PIP validation score of 91% (high confidence). The MCP provided a meaningful project rationale, completed a comprehensive data analysis and interpretation of results, and implemented robust interventions targeting member, provider, and MCP barriers. ABHWV demonstrated sustained improvement in the Annual Dental Visits for 2-3 Year Olds measure.
●	●	●	**Weakness.** ABHWV did not achieve statistically significant improvement in any of the PIP measures. **Recommendation.** A formal recommendation is not being issued, as performance in the dental PIP was negatively impacted by the COVID-19 public health emergency.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP			
★	★	★	**Strength.** ABHWV received a PIP validation score of 99% (high confidence). The MCP provided a meaningful project rationale and completed a comprehensive data analysis and interpretation of results. ABHWV implemented system-level interventions targeting member, provider, and MCP barriers, and adapted to COVID-19 public health emergency constraints quickly. The MCP demonstrated statistically significant improvement in the PIP measure.
●			**Weakness.** ABHWV did not specify a time period in the project aim statement. **Recommendation.** ABHWV should amend the project's aim statement and include a time period, such as the measurement year or life of the PIP.
Care for Adolescents PIP			
★	★	★	**Strength.** ABHWV received a PIP validation score of 92% (high confidence). Overall, the PIP was methodologically sound and included a meaningful project rationale.
●			**Weakness.** ABHWV did not specify a time period in the project aim statement, nor did it identify comparative goals or benchmarks. **Recommendation.** ABHWV should amend the project aim statement and include a time period, such as measurement year or life of the PIP, and include comparative goals or benchmarks to target.
MHT ABHWV - PERFORMANCE MEASURE VALIDATION			
★	★	★	**Strength.** ABHWV received an overall score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
MHT ABHWV - SYSTEMS PERFORMANCE REVIEW			
MCO Standards			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★	★	★	**Strength.** ABHWV received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** ABHWV provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** ABHWV provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** ABHWV provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** ABHWV provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** ABHWV provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** ABHWV provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** ABHWV provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** ABHWV provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** ABHWV provided evidence of meeting all Health Information Systems requirements.
Program Integrity Requirements Under the Contract			
★			**Strength.** ABHWV received a score of 100% (high confidence) for the Program Integrity Requirements Under the Contract Standard. The MCP provided evidence of meeting all program integrity contractual requirements.
MHT ABHWV - NETWORK ADEQUACY VALIDATION			
	●		**Weakness.** ABHWV scored 83% in successful provider contact for the 24/7 access survey. **Recommendation.** ABHWV should follow up with providers who could not be contacted and remedy deficiencies. Provider education and/or corrective action may be required.
	★	★	**Strength.** For providers successfully contacted, ABHWV received a score of 94% with the 24/7 access requirement. Overall, survey results determined providers directed members to care during nonbusiness hours.
MHT ABHWV - ENCOUNTER DATA VALIDATION			
★			**Strength.** ABHWV achieved an encounter data accuracy, or match rate, of 96%. Stakeholders can have confidence in the MCP's encounter/claims data.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
MHT ABHWV - GRIEVANCE, DENIAL, AND APPEAL FOCUSED STUDY			
Grievance Acknowledgement and Resolution Notification			
●	●	●	**Weakness.** ABHWV scored an 87% compliance rating for processing grievances. This score, which provides an opportunity for improvement, was attributed to untimely resolution notices during quarter 1 2020. ABHWV demonstrated timely resolution notification in quarters 2-4 2020. **Recommendation**. ABHWV should continue to follow its adjusted process, which demonstrates compliance.
Denial Resolution Notification			
★	★	★	**Strength.** ABHWV scored a 99% compliance rating for processing denials. Overall, the MCP provided timely resolution notification and communicated all required information to members, including the right to request an appeal.
Appeal Acknowledgement and Resolution Notification			
★	★	★	**Strength.** ABHWV scored a 100% compliance rating for processing appeals. The MCP provided timely resolution notification and communicated all required information to members, including the right to a fair hearing.

MHT THP

Table 49. MHT THP Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
MHT THP - PERFORMANCE IMPROVEMENT PROJECT VALIDATION			
Annual Dental Visits PIP			
★	★	★	**Strength.** THP received a PIP validation score of 95% (high confidence). The MCP demonstrated sustained and statistically significant improvement in both PIP measures.
●			**Weakness.** THP did not use a Plan-Do-Study-Act, or similar approach, to test improvement strategies. **Recommendation.** THP should implement the Plan-Do-Study-Act, or similar quality improvement approach, to facilitate performance improvement. The MCP should initiate a process to identify possible causes and solutions when intervention tests of change are not successful.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP			
★	★	★	**Strength.** THP received a PIP validation score of 96% (high confidence). The MCP exceeded its goal and demonstrated statistically significant improvement in the PIP measure.
●			**Weakness.** THP did not use a Plan-Do-Study-Act, or similar approach, to test improvement strategies. **Recommendation.** THP should implement the Plan-Do-Study-Act, or similar quality improvement approach, to facilitate performance improvement.
Promoting Health and Wellness in Children and Adolescents PIP			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★	★	★	**Strength.** THP documented a meaningful project rationale and conducted an analysis of telehealth services to better understand utilization and its impact. The MCP demonstrated sustained improvement in the BMI Percentile Documentation measure.
●			**Weakness.** THP did not specify a time period in the project aim statement. The MCP reported incorrect rates and analysis, and did not describe changes in performance between the last remeasurement and baseline performance. THP did not use a Plan-Do-Study-Act, or similar approach, to test improvement strategies. The MCP did not achieve statistically significant improvement in any of the PIP measures. **Recommendation.** THP should amend the aim statement and include a time period, such as the measurement year or life of the PIP. The MCP should introduce quality checks in its PIP reports to ensure accurate results and a complete analysis. THP should implement the Plan-Do-Study-Act, or similar quality improvement approach, to facilitate performance improvement.
MHT THP - PERFORMANCE MEASURE VALIDATION			
★	★	★	**Strength.** THP received an overall score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
MHT THP - SYSTEMS PERFORMANCE REVIEW			
MCO Standards			
★	★	★	**Strength.** THP received a score of 99% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	●	●	**Weakness.** THP did not meet all standards for timely access to care and services, nor did it communicate all standards in the Provider Manual. **Recommendation.** THP should demonstrate compliance with timely access to primary care, emergency care, and initial prenatal care. THP should update its Provider Manual to reflect all timely access standards. *(Compliance was subsequently demonstrated through a CAP.)*
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** THP provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** THP provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** THP provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** THP provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★			**Strength.** THP provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** THP provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** THP provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** THP provided evidence of meeting all Health Information Systems requirements.
Program Integrity Requirements Under the Contract			
★			**Strength.** THP received a score of 100% (high confidence) for the Program Integrity Requirements Under the Contract Standard. The MCP provided evidence of meeting all program integrity contractual requirements.
MHT THP - NETWORK ADEQUACY VALIDATION			
	★		**Strength.** THP scored 91% in successful provider contact for the 24/7 access survey. Survey results determined THP's Provider Directory is generally accurate.
	★	★	**Strength.** For providers successfully contacted, THP received a score of 97% with the 24/7 access requirement. Overall, survey results determined providers directed members to care during nonbusiness hours.
MHT THP - ENCOUNTER DATA VALIDATION			
★			**Strength.** THP achieved an encounter data accuracy, or match rate, of 96%. Stakeholders can have confidence in the MCP's encounter/claims data.
MHT THP - GRIEVANCE, DENIAL, AND APPEAL FOCUSED STUDY			
Grievance Acknowledgement and Resolution Notification			
★	★	★	**Strength.** THP scored a 100% compliance rating for processing grievances, including timely acknowledgment and resolution.
Denial Resolution Notification			
★	★	★	**Strength.** THP scored a 98% compliance rating for processing denials. Overall, the MCP provided timely resolution notification and communicated all required information to members, including the right to request an appeal.
Appeal Acknowledgement and Resolution Notification			
★	★	★	**Strength.** THP scored a 99% compliance rating for processing appeals. Overall, the MCP provided timely resolution notification and communicated all required information to members, including the right to a fair hearing.

MHT UHP

Table 50. MHT UHP Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
MHT UHP - PERFORMANCE IMPROVEMENT PROJECT VALIDATION			
Annual Dental Visits PIP			
★	★	★	**Strength.** UHP added a third measure to the PIP, Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk. The MCP demonstrated statistically significant and sustained improvement in this additional measure.
●	●	●	**Weakness.** UHP did not demonstrate statistically significant or sustained improvement in any of the mandated PIP measures. **Recommendation.** A formal recommendation is not being issued, as performance in the dental PIP was negatively impacted by the COVID-19 public health emergency.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP			
★	★	★	**Strength.** UHP received a PIP validation score of 99% (high confidence) and achieved statistically significant improvement in the PIP measure.
●			**Weakness.** UHP did not specify a time period in the project aim statement. **Recommendation.** UHP should amend the aim statement and include a time period, such as the measurement year or life of the PIP.
Immunizations for Adolescents PIP			
★	★	★	**Strength.** UHP received a PIP validation score of 100% (high confidence). The MCP reported a meaningful project rationale and methodologically sound baseline PIP.
MHT UHP - PERFORMANCE MEASURE VALIDATION			
★	★	★	**Strength.** UHP received an overall score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
MHT UHP - SYSTEMS PERFORMANCE REVIEW			
MCO Standards			
★	★	★	**Strength.** UHP received a score of 96% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	●	●	**Weakness.** UHP did not identify accurate timeliness to the initial prenatal care standard in its policy, nor was the standard included within its network analysis. **Recommendation.** UHP should amend its policy and network analysis to reflect members must have access to initial prenatal care within 14 days of the date on which the woman is found to be pregnant. *(Compliance was subsequently demonstrated through a CAP.)*
MCO Standards – Assurance of Adequate Capacity and Services			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
	●		**Weakness.** UHP's provider network-related policy did not address requirements for adequate access for basic hospital and tertiary services. **Recommendation.** UHP should update its policy and capture adequate access to basic hospital and tertiary services standards. *(Compliance was subsequently demonstrated through a CAP.)*
MCO Standards – Coordination and Continuity of Care			
●	●	●	**Weakness.** UHP did not have a policy that addressed coordinating services the MCP furnishes to the enrollee between settings; nor an appropriate policy requiring providers to maintain and share, as appropriate, an enrollee health record in accordance with professional standards or ensuring each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E. **Recommendation:** UHP should document its process for coordinating services between settings in an appropriate policy; the MCP should describe coordinating services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays; with the services the enrollee receives from any other MCP; with the services the enrollee receives in FFS Medicaid, and with the services the enrollee receives from the community and social support providers. UHP should update an appropriate policy to ensure each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards. UHP should amend an appropriate policy to ensure, in the process of coordinating care, each member's privacy is protected according to privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent they are applicable. *(Compliance was subsequently demonstrated through a CAP.)*
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** UHP provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** UHP provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** UHP provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** UHP provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** UHP provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★			**Strength.** UHP provided evidence of meeting all Health Information Systems requirements.
Program Integrity Requirements Under the Contract			
★			**Strength.** UHP received a score of 100% for the Program Integrity Requirements Under the Contract Standard. The MCP provided evidence of meeting all program integrity contractual requirements.
MHT UHP - NETWORK ADEQUACY VALIDATION			
	●		**Weakness.** UHP scored 86% in successful provider contact for the 24/7 access survey. **Recommendation.** UHP should follow up with providers who could not be contacted and remedy deficiencies. Provider education and/or corrective action may be required.
	★	★	**Strength.** For providers successfully contacted, UHP received a score of 100% with the 24/7 access requirement. Survey results determined providers directed members to care during nonbusiness hours.
MHT UHP - ENCOUNTER DATA VALIDATION			
★			**Strength.** UHP achieved an encounter data accuracy, or match rate, of 96%. Stakeholders can have confidence in the MCP's encounter/claims data.
MHT UHP - GRIEVANCE, DENIAL, AND APPEAL FOCUSED STUDY			
Grievance Acknowledgement and Resolution Notification			
★	★	★	**Strength.** UHP scored a 100% compliance rating for processing grievances, including timely acknowledgment and resolution.
Denial Resolution Notification			
★	★	★	**Strength.** UHP scored a 98% compliance rating for processing denials. Overall, the MCP provided timely resolution notification and communicated all required information to members, including the right to request an appeal.
Appeal Acknowledgement and Resolution Notification			
★	★	★	**Strength.** UHP scored a 95% compliance rating for processing appeals. Overall, the MCP provided timely resolution notification and communicated all required information to members, including the right to a fair hearing.

MHP ABHWV

Table 51. MHP ABHWV Strengths, Opportunities, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
MHP ABHWV - PERFORMANCE IMPROVEMENT PROJECT VALIDATION			
Annual Dental Visits PIP			
★	★	★	**Strength.** ABHWV received a PIP validation score of 100% (high confidence). The MCP provided a meaningful project rationale, described critical elements of its data collection plan, and identified member, provider, and MCP barriers for the proposal PIP.
Care for Adolescents PIP			

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
★	★	★	**Strength.** ABHWV received a PIP validation score of 98% (high confidence). The MCP provided a meaningful project rationale, described critical elements of its data collection plan, and identified member, provider, and MCP barriers for the proposal PIP.
●			**Weakness.** ABHWV did not specify a time period in the project aim statement. **Recommendation.** ABHWV should amend the project's aim statement and include a time period, such as the measurement year or life of the PIP.
Reducing Out-of-State Placements for Children in Foster Care PIP			
★	★	★	**Strength.** ABHWV received a PIP validation score of 98% (high confidence). Overall, the PIP was methodologically sound and included a meaningful project rationale.
●			**Weakness.** ABHWV did not specify a time period in the project aim statement. **Recommendation.** ABHWV should amend the project aim statement and include a time period, such as measurement year or life of the PIP.
MHP ABHWV - PERFORMANCE MEASURE VALIDATION			
★	★	★	**Strength.** ABHWV received an overall score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
MHP ABHWV - SYSTEMS PERFORMANCE REVIEW			
MCO Standards			
★	★	★	**Strength.** ABHWV received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	**Strength.** ABHWV provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
	★		**Strength.** ABHWV provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			
★	★	★	**Strength.** ABHWV provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	**Strength.** ABHWV provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★		**Strength.** ABHWV provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★			**Strength.** ABHWV provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★			**Strength.** ABHWV provided evidence of meeting all Subcontractual Relationships and Delegation requirements.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
MCO Standards – Practice Guidelines			
★	★	★	**Strength.** ABHWV provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★			**Strength.** ABHWV provided evidence of meeting all Health Information Systems requirements.
Program Integrity Requirements Under the Contract			
★			**Strength.** ABHWV received a score of 100% (high confidence) for the Program Integrity Requirements Under the Contract Standard. The MCP provided evidence of meeting all program integrity contractual requirements.
MHP ABHWV - NETWORK ADEQUACY VALIDATION			
	●		**Weakness.** ABHWV scored 76% in successful provider contact for the 24/7 access survey. **Recommendation.** ABHWV should follow up with providers who could not be contacted and remedy deficiencies. Provider education and/or corrective action may be required.
	★	★	**Strength.** For providers successfully contacted, ABHWV received a score of 95% with the 24/7 access requirement. Overall, survey results determined providers directed members to care during non-business hours.
MHP ABHWV - ENCOUNTER DATA VALIDATION			
★			**Strength.** ABHWV achieved an encounter data accuracy, or match rate, of 97%. Stakeholders can have confidence in the MCP's encounter/claims data.
MHP ABHWV - GRIEVANCE, DENIAL, AND APPEAL FOCUSED STUDY			
Grievance Acknowledgement and Resolution Notification			
●	●	●	**Weakness.** ABHWV scored a 67% compliance rating for processing grievances. This score, which provides an opportunity for improvement, was attributed to untimely resolution notices during quarter 1 2020. ABHWV demonstrated timely resolution notification in quarters 2-4 2020. **Recommendation**. ABHWV should continue to follow its adjusted process, which demonstrates compliance.
Denial Resolution Notification			
★	★	★	**Strength.** ABHWV scored a 100% compliance rating for processing denials. The MCP provided timely resolution notification and communicated all required information to members, including the right to request an appeal.
Appeal Acknowledgement and Resolution Notification			
★	★	★	**Strength.** ABHWV scored a 100% compliance rating for processing appeals. The MCP provided timely resolution notification and communicated all required information to members, including the right to a fair hearing.

Assessment of Previous Recommendations

During the course of conducting 2021 EQR activities, Qlarant evaluated MCP compliance in addressing previous annual recommendations.[18] Assessment outcomes, included in Tables 52-55, identify if the MCP adequately addressed 2020 recommendations. Color coded symbols specify results:

- The MCP adequately addressed the recommendation.
- The MCP demonstrated some improvement but did not fully address the recommendation.
- The MCP did not adequately address the recommendation.

MHT ABHWV

Qlarant made two recommendations for ABHWV during the 2020 EQR. A 2021 assessment concluded ABHWV adequately addressed one recommendation (50%) and demonstrated some improvement in the second recommendation (50%). Table 52 includes follow-up assessment results.

Table 52. MHT ABHWV Assessment of Previous Annual Recommendations

2020 Recommendation	2021 Assessment
MHT ABHWV - PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
There were no formal 2020 recommendations for ABHWV.	
MHT ABHWV - PERFORMANCE MEASURE VALIDATION	
There were no formal 2020 recommendations for ABHWV.	
MHT ABHWV - SYSTEMS PERFORMANCE REVIEW	
There were no formal 2020 recommendations for ABHWV.	
MHT ABHWV - NETWORK ADEQUACY VALIDATION	
ABHWV should follow up with providers who could not be contacted for the 24/7 access survey. Provider education and/or corrective action may be required. The MCP scored 81% compliance in the 2020 survey measuring successful provider contact.	ABHWV scored 83% compliance with successful provider contact in the 2021 survey. The MCP demonstrated some improvement but continues to have opportunity. This recommendation remains in place for 2021.
MHT ABHWV - ENCOUNTER DATA VALIDATION	
There were no formal 2020 recommendations for ABHWV.	
MHT ABHWV - GRIEVANCE, DENIAL, AND APPEAL FOCUSED STUDY	
Grievance Acknowledgement and Resolution Notification	
ABHWV should determine the root cause of its delay in providing timely grievance resolution notifications to members and make process adjustments accordingly.[19]	ABHWV adjusted its process. After scoring 33% compliance with timely grievance resolution notifications in quarter 1 2020, the MCP scored 100% in quarters 2-4.

[18] In some instances one recommendation may summarize or capture multiple, but similar, issues. The number of recommendations per MCP should not be used to gauge MCP performance alone.

[19] Due to the lag in reporting, which occurs approximately 105 days after the close of the quarter, to permit time for grievance resolution and the reporting process, Qlarant's recommendation was based on a review of quarters 1 and 2 2020 only.

MHT THP

Qlarant made five recommendations for THP during the 2020 EQR. The 2021 assessment determined THP adequately addressed four recommendations (80%). The MCP did not adequately address one recommendation (20%). Table 53 includes follow-up assessment results.

Table 53. MHT THP Assessment of Previous Annual Recommendations

2020 Recommendation	2021 Assessment
MHT THP - PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Annual Dental Visits PIP	
THP had a limited number of interventions targeting provider barriers in its Annual Dental Visits PIP. The MCP should conduct a thorough barrier analysis and initiate more robust interventions to drive performance improvement, including provider-targeted interventions.	⮝ THP initiated multiple interventions targeting barriers including distribution of provider gaps in care reports, education for providers, and execution of an alternate provider payment model agreement which included children's dental services as a metric.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP	
THP's barrier analysis was limited. THP should conduct a comprehensive barrier analysis examining member, provider, and MCP barriers. The MCP should identify barriers of change so effective improvement strategies can be developed to address them.	⮝ THP identified member, provider, and MCP barriers in its annual barrier analysis and initiated interventions targeting each group. Most notably, telehealth services were offered to members, which addressed multiple barriers.
Promoting Health and Wellness in Children and Adolescents PIP	
THP included errors in results. THP should add a validation step to its reporting process to ensure the accuracy of results prior to report submission.	⮟ While THP's PIP worksheet included accurate rates, the PIP report included errors in rates and analysis. This recommendation remains in place for 2021.
MHT THP - PERFORMANCE MEASURE VALIDATION	
There were no formal 2020 recommendations for THP.	
MHT THP - SYSTEMS PERFORMANCE REVIEW	
Availability of Services & Assurance of Adequate Capacity and Services	
THP did not have a policy or provider agreement requiring the provider to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members. THP should add this requirement to an access-related policy and the provider agreement.	⮝ THP updated its access-related policy and provider agreement as recommended.
MHT THP - NETWORK ADEQUACY VALIDATION	
THP should follow up with providers who could not be contacted for the 24/7 access survey. Provider education and/or corrective action may be required. The MCP scored 84% compliance in the 2020 survey measuring successful provider contact.	⮝ THP acted to improve compliance with provider access. The 2021 survey yielded an acceptable rate of 91% compliance.
MHT THP - ENCOUNTER DATA VALIDATION	
There were no formal 2020 recommendations for THP.	
MHT THP - GRIEVANCE, DENIAL, AND APPEAL FOCUSED STUDY	
There were no formal 2020 recommendations for THP.	

MHT UHP

Qlarant made nine recommendations for UHP during the 2020 EQR. A 2021 assessment demonstrated UHP adequately addressed eight recommendations (89%) and demonstrated some improvement in the remaining recommendation (11%). Table 54 includes follow-up assessment results.

Table 54. MHT UHP Assessment of Previous Annual Recommendations

2020 Recommendation	2021 Assessment
MHT UHP - PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Annual Dental Visits PIP	
UHP executed weak interventions. UHP should implement interventions that are more rigorous, including evidence-based strategies creating change(s) in behavior. UHP should consider instituting a "gaps in care" intervention with large dental providers. By identifying members missing their annual dental visit, targeted outreach can be conducted by both the MCP and dental providers. UHP may want to engage these dental providers with incentives for reaching identified goals for routine dental visits.	⮝ UHP carried out multiple interventions targeting barriers including member and provider incentives, distribution of provider gaps in care reports, and education for providers, among other interventions.
MHT UHP - PERFORMANCE MEASURE VALIDATION	
UHP had data entry errors in its final rate worksheet and had to resubmit rates. UHP should introduce a validation step as part of the final rate submission process. This should eliminate errors in reporting rates.	⮝ UHP reported accurate rates in its final rate worksheet.
MHT UHP - SYSTEMS PERFORMANCE REVIEW	
Availability of Services & Assurance of Adequate Capacity and Services	
UHP's policy on provider network standards did not require monitoring of networks for members with limited English proficiency or physical or mental disabilities. UHP should amend its policy and require monitoring of networks for members with limited English proficiency or physical or mental disabilities.	⮝ UHP revised its policy on provider network standards and requires monitoring of networks for members with limited English proficiency or physical or mental disabilities.
UHP's Member Handbook did not explain second opinions may be obtained at no cost to the member. UHP should add language to its Member Handbook specifying the MCP provides for a second opinion from a network provider, or arranges for the member to obtain one out-of-network, at no cost to the member.	⮝ UHP added second opinion language, at no cost to the member, to its Member Handbook as recommended.

2020 Recommendation	2021 Assessment
UHP did not have a policy requiring the MCP to coordinate payment with out-of-network providers and ensure the cost to the member is no greater than it would be if the services were furnished within the network. UHP should develop a policy addressing the requirement to coordinate payment with out-of-network providers and ensure the cost to the member is no greater than it would be if the services were furnished within the network.	UHP added policy language on coordinating payment with out-of-network providers as recommended.
UHP did not provide clear and consistent evidence of targeting corrective actions toward providers failing to meet network adequacy standards. UHP should require corrective actions of providers failing to meet network adequacy standards. The MCP should provide evidence of corrective actions. UHP should consider a tracking system such as a spreadsheet with the date the issue was identified, provider name, nature of the issue, date letter sent, date resurveyed, results of resurveying, and additional follow-up if required.	UHP addressed the deficiency and required corrective actions of providers failing to meet network adequacy standards.
UHP did not have a policy addressing how the MCP collects and reports network changes to the State. UHP should develop a policy describing how the MCP collects and reports network changes to BMS	UHP added policy language as recommended.
MHT UHP - NETWORK ADEQUACY VALIDATION	
UHP should follow up with providers who could not be contacted for the 24/7 access survey. Provider education and/or corrective action may be required. The MCP scored 83% compliance in the 2020 survey measuring successful provider contact.	UHP scored 86% compliance with successful provider contact in the 2021 survey. The MCP demonstrated some improvement, but continues to have opportunity. This recommendation remains in place for 2021.
MHT UHP - ENCOUNTER DATA VALIDATION	
There were no formal 2020 recommendations for UHP.	
MHT UHP - GRIEVANCE, DENIAL, AND APPEAL FOCUSED STUDY	
Appeal Acknowledgement and Resolution Notification	
UHP did not consistently acknowledge appeals in a timely manner, nor did it consistently include all required content in the appeal notification letters. UHP should ensure consistent timely acknowledgment of requests for appeal and include all required documentation in the resolution notices. Specifically, for appeals not resolved wholly in favor of members, notification should include the right to request a fair hearing and other rules related to rights and procedures.	UHP demonstrated improvement in 2021 and scored a 95% compliance rating in appeal acknowledgment and resolution notification to members.

MHP ABHWV

Qlarant made two recommendations for ABHWV during the 2020 EQR. A 2021 assessment concluded ABHWV adequately addressed one recommendation (50%), but not the other (50%). Table 55 includes follow-up assessment results.

Table 55. MHP ABHWV Assessment of Previous Annual Recommendations

2020 Recommendation	2021 Assessment
MHP ABHWV - PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Not applicable; PIP validation for the new MHP program did not occur until 2021.	
MHP ABHWV - PERFORMANCE MEASURE VALIDATION	
Not applicable; PMV for the new MHP program did not occur until 2021.	
MHP ABHWV - SYSTEMS PERFORMANCE REVIEW	
Not applicable; SPR for the new MHP program did not occur until 2021.	
MHP ABHWV - NETWORK ADEQUACY VALIDATION	
ABHWV should follow up with providers who could not be contacted for the 24/7 access survey. Provider education and/or corrective action may be required. The MCP scored 83% compliance in the 2020 survey measuring successful provider contact.	ABHWV scored 76% compliance with successful provider contact in the 2021 survey. The MCP demonstrated a decline in performance. This recommendation remains in place for 2021.
MHP ABHWV - ENCOUNTER DATA VALIDATION	
Not applicable; EDV for the new MHP program did not occur until 2021.	
MHP ABHWV - GRIEVANCE, DENIAL, AND APPEAL FOCUSED STUDY	
Grievance Acknowledgement and Resolution Notification	
ABHWV should determine the root cause of its delay in providing timely grievance resolution notifications to members and make process adjustments accordingly.	ABHWV adjusted its process. After scoring 0% compliance with timely grievance resolution notification in quarter 1 2020 (only one grievance was received for the quarter), the MCP provided timely resolution notifications for all other grievances received during the year.

State Recommendations

As identified in the introduction of this report, the State aims to deliver high quality, accessible care to managed care members. To achieve this goal, BMS and WVCHIP developed a framework to focus quality improvement efforts for the managed care programs, which is documented in the *West Virginia Managed Care Quality Strategy*. Goals and objectives are identified in Table 56.

Table 56. West Virginia Managed Care Program Goals and Objectives

Goal	Objective
1. Promote a health care delivery system that consistently offers: • Timely access to health care • High clinical quality, including use of evidence-based models of treatment • Care at the appropriate time to deter avoidable use of emergency and acute care • Children and adolescents' access to primary care according to the periodicity schedule	**1.** Offer a wide range of physical, behavioral health, and social services to address whole-person health. **2.** Improve child wellness and PCP visit rates. **3.** Improve the rate of medically necessary EPSDT utilization. **4.** Expand use of health care services that offer preventive value (e.g., vaccinations, well-child visits, annual examinations).
2. Offer tools and supports that empower individuals to self-manage their health, whole-person and whole-household wellness, and use of health care services.	**1.** Implement sound person-centered planning that addresses the whole person and advances individual and family goals. **2.** Improve screening and referral for social determinants of health (SDoH) including the use of Z-Codes for need and impact measurement. **3.** Use care transition supports to empower patient education, timely and effective post-discharge follow-up while assessing strategies to avoid re-hospitalization and risk reduction
3. Promote effective communication and team-based care to better coordinate care across the full continuum of health care.	**1.** Improve acute care hospitalization follow-up rates. **2.** Improve care for mothers and infants (e.g., immunization rates, postpartum visits, etc.). **3.** Implement team-based care coordination models using evidence-based practices to move to holistic, multidisciplinary care coordination.
4. Reduce the incidence of targeted conditions that negatively impact health and quality of life, including: • Cardiovascular disease and its contributors (cholesterol and hypertension) • Chronic respiratory disease (chronic obstructive pulmonary disease (COPD), asthma, and other conditions related to smoking) • Depression • Diabetes • Opioid misuse • Obesity	**1.** Improve hospital-acquired infection metrics. **2.** Improve chronic condition metrics (e.g., diabetes, smoking, etc.). **3.** Implement population health management tailored to conditions using a combination of evidence-based practices and community-based customization. **4.** Advance tools and supports that empower improved individual health behaviors related to priorities such as (a) nutrition, (b) exercise, (c) reduce/eliminate the use of tobacco, alcohol, and other substances, (d) sexual health and family planning, and (e) mental wellness.
5. Strengthen State oversight of programs to maximize partnership with contracted MCPs as committed partners to driving health impacts and acting as good stewards of resources.	**1.** Monitor member satisfaction scores. **2.** Ensure timely MCP reporting per contract standards. **3.** Implement updated continuous quality improvement practices to enhance partnership.

Source: *West Virginia Managed Care Quality Strategy Mountain Health Trust and Mountain Health Promise* [20]

[20] West Virginia Managed Care Quality Strategy

Recommendations on How the State can Target Quality Strategy Goals and Objectives

The intent of the Quality Strategy is to provide an overarching framework for BMS and WVCHIP to drive quality and performance improvement among its contracted MCPs, with the ultimate goal of improving health outcomes for its members. In many instances, MCPs have developed strategies to meet and achieve goals. An analysis of HEDIS and CAHPS survey measures included in Appendix A1 and A2, respectively, demonstrate MCP averages are meeting and exceeding national average benchmarks in many measures relating to the effectiveness of care, access and availability of services, preventive care utilization, and member experience of care. Figures 32 and 33 illustrate the WV MCP averages performed better than national averages in 69% of select HEDIS measures and 54% of CAHPS survey measures.

Figure 32. MY 2020 HEDIS MCP Average Performance Compared to Benchmarks

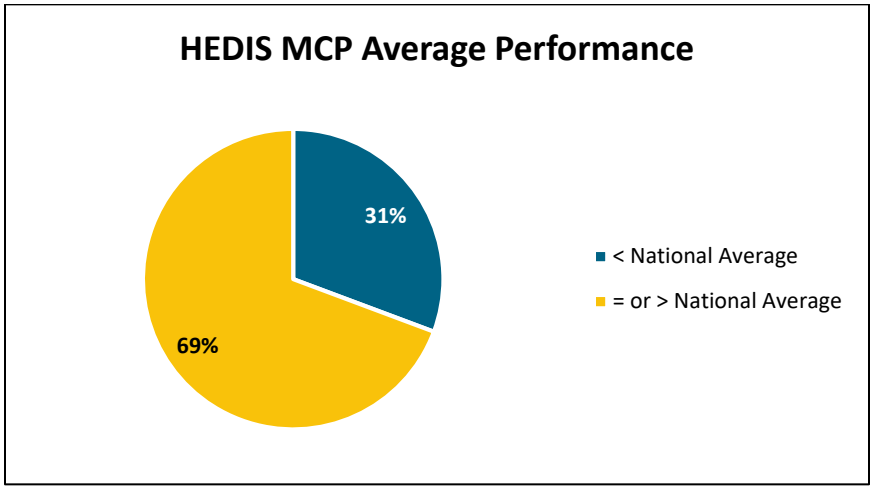
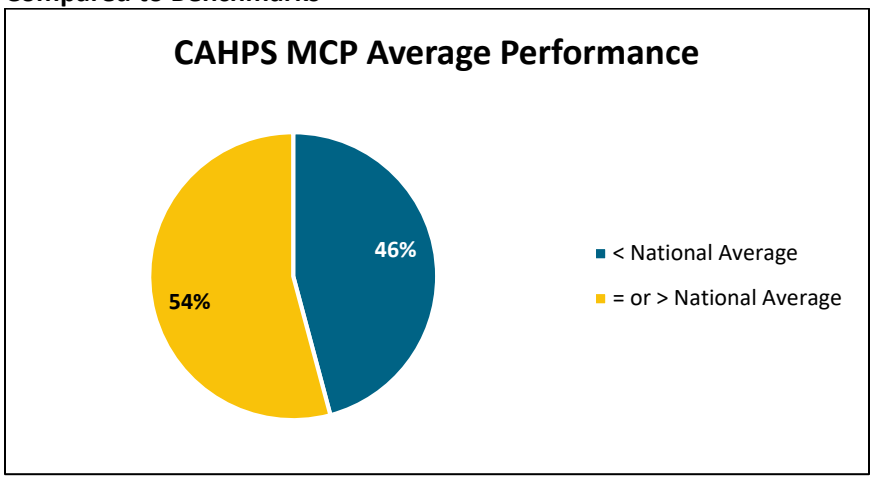


Figure 33. MY 2020 CAHPS Survey MCP Average Performance Compared to Benchmarks



While the MCPs are demonstrating their commitment to quality and improving health outcomes, there continues to be opportunity to achieve additional improvements. Qlarant makes several recommendations below for BMS and WVCHIP to consider. Recommendations describe how the State can target Quality Strategy goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services furnished to managed care members.

As previously stated, Qlarant reports on key measures from the CAHPS experience of care survey in Appendix A2. The MCPs performed better on child measures than adult measures. An analysis focused only on adult measures reveals 75% of measures compared unfavorably to national average benchmarks. ***Qlarant recommends*** BMS review adult CAHPS survey performance and identify one or more measures for the MCPs to target and direct strategies to improve performance. For example, Qlarant recommends MCPs aim to improve performance in the Rating of Health Plan and/or Coordination of Care measure. Improved customer service, communication, and care coordination impacts a myriad of other priority areas including providing care that is person-centered, at the appropriate time, and is followed up when appropriate. Monitoring member satisfaction is an explicit Goal 5 objective.

After the MCPs report MY 2021 performance in 2022 for the Annual Dental Visits PIP, they will have reported four years of remeasurement results. Analysis of MY 2020 results indicates the MHT MCP weighted average for both PIP measures, Annual Dental Visits for 2-3 Year Olds and Percentage of Eligible Children that Received Preventative Dental Services, exceeded national average benchmarks. ***Qlarant recommends*** the State close out the Annual Dental Visits PIP and implement a replacement PIP targeting Goal 4, which includes reducing the incidence of conditions that negatively impact health and quality of life. Examples of conditions to target include smoking and obesity.

The MCPs are required to conduct an initial health assessment, or screening, of each member's needs upon enrollment. Barriers exist to obtaining health information from members, which can negatively impact care coordination and management. ***Qlarant recommends*** the State establish targets for the MCPs to complete initial health assessments within 30, 60, and 90 days. MCPs should make multiple attempts to obtain and complete screenings. These assessments provide valuable information including identification of risk factors such as social determinants of health (SDoH), chronic conditions, substance use, mental health disorders, and other health and safety issues. If MCPs improve compliance in completing these screenings, they can achieve improvements related to Goals 1-3. Specifically, MCPs can offer or coordinate a wide range of physical, behavioral health, and social services to address whole-person health and promote effective communication and team-based care to better coordinate care across the full continuum of health care.

Confidence levels, in MCP compliance, have been established for EQR tasks including PIP validation, PMV, and SPRs. For example, an MCP scoring between 95% and 100% in the SPR task is assigned a high confidence level, meaning stakeholders can have high confidence in the MCP's level of compliance with structural and operational standards. Levels of confidence have not been established for NAV, EDV, or the Grievance, Appeal, and Denial Focused Study. ***Qlarant recommends*** the State work with the EQRO to establish confidence levels in these activities, so all EQR tasks have clear thresholds to assist the MCPs in driving process improvement activities. This recommendation aligns with Goal 5, which strengthens State oversight of programs to maximize partnership with contracted MCPs, and more specifically ensures MCP reporting per contract standards and implements updated continuous quality improvement practices.

Improved mental health can lead to improved overall physical health. West Virginia's MCP weighted averages for Follow-Up After Emergency Department Visit for Mental Illness (7 Day and 30 Day Follow-Up) and Follow-Up After Hospitalization for Mental Illness (7 Day and 30 Day Follow-Up) measures present an opportunity for improvement with three of the four metrics not meeting the national average benchmarks. ***Qlarant recommends*** the State consider establishing a quality improvement initiative or PIP aimed at improving performance in the mental health-related measures. This recommendation supports quality improvement efforts related to Goal 1, which promotes a health care delivery system offering a wide range of physical and behavioral health and social services to address whole-person health.

As reported by the Office of the Assistant Secretary for Planning & Evaluation, US Department of Health & Human Services, the COVID-19 crisis has disparately harmed low-income households. Systemic inequalities in employment, wage-earning, health, and well-being have been strained for sub-populations facing poverty or near-poverty conditions. Economic uncertainties associated with the COVID-19 pandemic increased stress levels for many individuals and families, impacting mental health and overall well-being.[21] ***Qlarant recommends*** the State consider a quality improvement initiative related to improving the COVID-19 vaccination status of managed care members. This recommendation aligns with Goal 1, which promotes a health care delivery system expanding the use of health care services offering preventive value, including vaccinations.

Conclusion

As West Virginia's contracted EQRO, Qlarant evaluated the MHT and MHP managed care programs to assess compliance with federal and state-specific requirements. Review and validation activities occurred over the course of 2021 and assessed MY 2020 and MY 2021 performance, as applicable. Qlarant evaluated each participating MCP and found:

- Overall, MCPs understand how to conduct PIPs in a methodical manner.
    - MHT MCPs achieved statistically significant improvement in the BMS mandated PIP, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence.
    - Despite MHT MCP implementation of systematic interventions for the Annual Dental Visits PIP, performance declined for two of three MCPs; this decline was likely due to COVID-19 public health emergency barriers.
    - THP was the only MHT MCP reporting remeasurement results for the MCP selected PIPs and achieved sustained improvement in one Promoting Health and Wellness in Children and Adolescents project measure.
    - MHP ABHWV's PIPs, all of which were baseline or proposal submissions, were assessed with high confidence in meeting PIP foundation and structure requirements.
- MCPs had appropriate systems in place to process accurate claims and encounters, as demonstrated in the PMV activity. Measure results were assessed as "reportable." An analysis of PMs with benchmarks included in the PMV activity demonstrates MY 2020 MHT MCP weighted averages met or exceeded national average benchmarks in 18 of 35 (51%) measures. MY 2020 MHP ABHWV rates met or exceeded national average benchmarks in six of 10 (60%) PMV measures.

[21] The Impact of the First Year of the COVID-19 Pandemic and Recession on Families with Low Incomes

- MCPs demonstrated compliance with federal and state requirements in the SPR ranging from 96% to 100%. MCPs not achieving full compliance conducted CAPs, which were approved and closed through quarterly monitoring.
- There is opportunity to improve successful contact with providers after regular business hours for the NAV study. The MHT MCP average was 87% and MHP ABHWV average was 76%. The most frequent reason for unsuccessful contact was due to the phone number not reaching the intended provider. In instances where successful provider contact was achieved, Qlarant determined provider offices appropriately directed members to care—all MCPs achieved 94% compliance, or greater, with the provider 24/7 access requirement.
- An evaluation of claims data yielded a high level of encounter data accuracy as evidenced by supporting medical record documentation in the EDV activity. The MHT MCP average match rate was 96%. MHP ABHWV achieved a match rate of 97%.
- Overall, the MHT MCPs performed well in resolving and/or providing timely notice to members for grievances, denials, and appeals, having scored averages of 96%, 98%, and 98%, respectively. MHP ABHWV's performance ranged from a low compliance rating for grievances (67%) to fully compliant ratings for denials and appeals (100%). Caution is advised when interpreting ABHWV's grievance compliance rate, as the MCP only received five grievances for the year. The MCP remedied its process during the year and appropriately provided timely resolution notice after making the adjustment.
- MCP averages for the selected HEDIS and CAHPS survey measures, identified in Appendix A1 and A2, respectively, compared favorably to national average benchmarks for the majority of measures.

West Virginia's managed care programs continue to make strides and improve the quality of and access to health care services for its Medicaid and CHIP members. These beneficial gains are expected to improve health outcomes in the populations served. All MCPs demonstrate their commitment to quality and quickly respond to recommendations or requests for corrective actions. BMS and WVCHIP should continue to monitor, assess, and improve priority areas and consider Qlarant recommendations, which target Quality Strategy goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services furnished to managed care members.

Appendix 1 - HEDIS® Measures Collected and Reported to NCQA

The HEDIS performance measure tables include select 2021 (MY 2020) results for each managed care plan (MCP). The tables also display MCP weighted averages compared to the NCQA Quality Compass Medicaid HMO benchmarks. Results of this comparison are made via a diamond rating system.

NCQA Quality Compass National Medicaid Percentile Ranges	Comparison to Benchmarks
The MCP Weighted Average is below the NCQA Quality Compass National Medicaid HMO Average.	♦
The MCP Weighted Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75th Percentile.	♦ ♦
The MCP Weighted Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid HMO.	♦ ♦ ♦

Effectiveness of Care Domain

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	63.12	75.83	69.29	69.48	♦ ♦ ♦
Antidepressant Medication Management - Effective Acute Phase Treatment	51.18	65.94	58.94	58.11	♦ ♦
Antidepressant Medication Management - Effective Continuation Phase Treatment	36.03	53.15	43.66	43.53	♦ ♦
Appropriate Testing for Pharyngitis - Total (3-65+ Yrs)	73.35	70.65	71.53	71.97	♦
Appropriate Treatment for Upper Respiratory Infection - Total (3 Mos - 65+ Yrs)	78.82	79.29	76.21	77.74	♦
Asthma Medication Ratio - Total (5-64 Yrs)	63.96	57.51	65.01	62.83	♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis - Total (3 Mos - 65+ Yrs)	40.86	39.08	39.42	39.83	♦

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Breast Cancer Screening	45.05	46.48	47.71	46.44	♦
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	66.67	73.68	69.77	70.59	♦
Cardiac Rehabilitation - Initiation - Total (18-65+ Yrs)*	2.51	2.48	2.23	2.40	**NC**
Cardiac Rehabilitation - Engagement 1 Total (18-65+ Yrs)*	3.86	2.48	3.26	3.22	**NC**
Cardiac Rehabilitation - Engagement 2 Total (18-65+ Yrs)*	2.51	1.45	2.40	2.15	**NC**
Cardiac Rehabilitation - Achievement Total (18-65+ Yrs)*	1.16	0.62	0.51	0.76	**NC**
Cervical Cancer Screening	53.04	40.15	53.28	49.72	♦
Childhood Immunization Status - Combination 2	74.94	71.53	76.64	74.84	♦ ♦
Childhood Immunization Status - Combination 3	71.05	67.64	74.70	71.76	♦ ♦
Childhood Immunization Status - Combination 4	70.56	67.64	73.97	71.28	♦ ♦
Childhood Immunization Status - Combination 5	64.23	57.91	70.56	65.36	♦ ♦ ♦
Childhood Immunization Status - Combination 6	36.50	36.98	41.61	38.71	♦
Childhood Immunization Status - Combination 7	63.99	57.91	69.83	64.97	♦ ♦ ♦
Childhood Immunization Status - Combination 8	36.50	36.98	41.61	38.71	♦
Childhood Immunization Status - Combination 9	34.06	33.09	39.66	36.13	♦
Childhood Immunization Status - Combination 10	34.06	33.09	39.66	36.13	♦
Childhood Immunization Status - DTaP	77.62	73.48	78.83	77.15	♦ ♦
Childhood Immunization Status - Hepatitis A	88.56	88.08	89.54	88.85	♦ ♦ ♦
Childhood Immunization Status - Hepatitis B	93.19	91.73	93.67	93.05	♦ ♦ ♦
Childhood Immunization Status - HiB	88.56	88.32	90.27	89.21	♦ ♦
Childhood Immunization Status - Influenza	42.58	44.53	46.23	44.53	♦
Childhood Immunization Status - IPV	91.97	87.83	90.75	90.51	♦ ♦
Childhood Immunization Status - MMR	89.05	87.35	89.05	88.65	♦ ♦
Childhood Immunization Status - Pneumococcal Conjugate	77.37	73.97	81.75	78.38	♦ ♦
Childhood Immunization Status - Rotavirus	77.62	70.07	82.24	77.76	♦ ♦ ♦
Childhood Immunization Status - VZV	88.32	87.59	87.59	87.85	♦ ♦

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Chlamydia Screening in Women - Total (16-24 Yrs)	47.95	42.15	44.22	44.95	♦
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	66.18	54.50	62.77	61.68	♦ ♦
Comprehensive Diabetes Care - Eye Exams	33.33	36.74	36.25	35.38	♦
Comprehensive Diabetes Care - HbA1c Testing	85.89	83.70	87.10	85.76	♦ ♦
Comprehensive Diabetes Care - HbA1c Control (<8%)	47.69	47.69	43.07	45.91	♦ ♦
Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%) ***Lower rate is better***	41.61	41.36	47.20	43.69	♦ ♦
Controlling High Blood Pressure	62.04	56.20	61.56	60.32	♦ ♦
Diabetes Monitoring for People with Diabetes and Schizophrenia	66.67	68.14	69.91	68.35	♦ ♦
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	79.80	72.98	78.32	77.12	♦ ♦
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up - Total (13-18+ Yrs)	38.63	41.62	40.47	40.23	♦ ♦ ♦
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up - Total (13-18+ Yrs)	47.18	50.28	48.69	48.69	♦ ♦ ♦
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up - Total (6-65+ Yrs)	34.88	34.19	32.61	33.85	♦
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up - Total (6-65+ Yrs)	52.00	48.50	50.08	50.35	♦
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up - Total (13-65+ Yrs)*	30.58	31.90	28.84	11.09	♦
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up - Total (13-65+ Yrs)*	55.34	53.39	49.38	52.96	♦ ♦
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up - Total (6-65+ Yrs)	41.93	36.61	35.70	38.27	♦
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up - Total (6-65+ Yrs)	65.71	59.98	62.41	63.03	♦ ♦

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	56.79	53.28	48.61	52.45	♦ ♦ ♦
Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	64.46	60.54	58.62	61.12	♦ ♦
Immunizations for Adolescents - Combination 1	85.89	82.24	86.62	85.54	♦ ♦
Immunizations for Adolescents - Combination 2	30.90	27.25	29.93	29.71	♦
Immunizations for Adolescents - HPV	31.39	27.49	30.41	30.15	♦
Immunizations for Adolescents - Meningococcal	85.89	83.21	87.10	85.96	♦ ♦
Immunizations for Adolescents - Tdap/Td	88.08	83.94	88.32	87.39	♦ ♦
Kidney Health Evaluation for Patients With Diabetes - Total (18-85 Yrs)*	23.41	19.93	23.70	22.57	**NC**
Lead Screening in Children	58.64	53.08	58.39	57.24	♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing - Total (1-17 Yrs)	75.08	64.08	74.39	71.32	♦ ♦ ♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing - Total (1-17 Yrs)	63.93	57.47	65.26	62.43	♦ ♦ ♦
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing - Total (1-17 Yrs)	63.28	53.74	64.59	60.80	♦ ♦ ♦
Non-Recommended Cervical Cancer Screening in Adolescent Females ***Lower rate is better***	1.95	0.67	1.59	1.50	♦
Persistence of Beta-Blocker Treatment after a Heart Attack	85.50	93.02	88.31	88.89	♦ ♦ ♦
Pharmacotherapy for Opioid Use Disorder - Total (16-65+ Yrs)	26.89	35.29	30.31	30.55	♦ ♦
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	84.45	88.11	84.62	85.68	♦ ♦
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	82.48	84.46	71.71	79.35	♦ ♦ ♦

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Risk of Continued Opioid Use >= 15 Days (Total) ***Lower rate is better***	7.05	10.24	8.62	8.50	♦
Risk of Continued Opioid Use >= 31 Days (Total) ***Lower rate is better***	3.76	4.98	4.32	4.29	♦
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (21-75 Yrs Male)	83.90	80.99	81.26	82.04	♦ ♦
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (40-75 Yrs Female)	81.28	81.18	80.25	80.84	♦ ♦
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	82.64	81.08	80.74	81.45	♦ ♦
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (21-75 Yrs Male)	70.25	81.18	74.05	74.95	♦ ♦
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (40-75 Yrs Female)	69.08	81.50	72.63	74.07	♦ ♦
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	69.70	81.33	73.33	74.52	♦ ♦
Statin Therapy for Patients With Diabetes - Received Statin Therapy	65.63	66.18	67.14	66.37	♦ ♦
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	66.68	79.12	71.95	72.20	♦ ♦
Use of Imaging Studies for Low Back Pain	66.38	65.54	69.27	67.39	♦
Use of Opioids at High Dosage (HDO) ***Lower rate is better***	1.13	1.51	1.86	1.51	♦ ♦ ♦
Use of Opioids From Multiple Providers - Multiple Pharmacies ***Lower rate is better***	2.47	1.72	1.01	1.70	♦ ♦ ♦
Use of Opioids From Multiple Providers - Multiple Prescribers ***Lower rate is better***	10.57	10.20	11.11	10.67	♦ ♦ ♦

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies ***Lower rate is better***	1.24	1.05	0.52	0.91	♦ ♦ ♦
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	22.27	24.81	22.16	22.92	♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile - Total (2-17 Yrs)	80.78	80.54	86.13	83.13	♦ ♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition - Total (2-17 Yrs)	72.26	69.34	72.99	72.02	♦ ♦
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity - Total (2-17 Yrs)	71.29	61.31	72.26	69.78	♦ ♦

+ ABHWV's HEDIS measure rates reflect performance in all Medicaid populations (MHT and MHP) per NCQA reporting requirements.
* New Measure introduced in MY 2020
NC - No Comparison (no benchmark available)
NR - Not Reported

Access and Availability Domain

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Adults' Access to Preventive/ Ambulatory Health Services - Total (20-65+ Yrs)	78.83	77.13	79.39	78.58	♦ ♦
Annual Dental Visit (2-3 Yrs)	38.32	30.77	33.84	34.70	♦ ♦
Annual Dental Visit - Total (2-20 Yrs)	56.82	50.02	53.95	54.08	♦ ♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence - Total (13-18+ Yrs)	42.35	41.08	54.08	46.30	♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence - Total (13-18+ Yrs)	69.78	74.43	75.37	73.08	♦ ♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment – Initiation of AOD – Other Drug Abuse or Dependence - Total (13-18+ Yrs)	44.73	44.36	52.5	47.47	♦ ♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-18+ Yrs)	52.54	54.43	60.59	55.99	♦ ♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence - Total (13-18+ Yrs)	14.48	15.63	15.5	15.18	♦ ♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence - Total (13-18+ Yrs)	51.75	53.1	54.33	53.04	♦ ♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence - Total (13-18+ Yrs)	16.56	19.05	19.23	18.22	♦ ♦ ♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-18+ Yrs)	29.23	30.28	30.53	30.00	♦ ♦ ♦

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Prenatal and Postpartum Care - Timeliness of Prenatal Care	91.00	83.94	87.83	87.98	♦ ♦
Prenatal and Postpartum Care - Postpartum Care	77.62	69.59	75.91	74.98	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total (1-17 Yrs)	58.91	47.69	41.72	44.37	♦

+ ABHWV's HEDIS measure rates reflect performance in all Medicaid populations (MHT and MHP) per NCQA reporting requirements.
* New Measure introduced in MY 2020
NC - No Comparison (no benchmark available)
NR - Not Reported

Utilization Domain

HEDIS Performance Measures	ABHWV+ %	THP %	UHP %	MCP Weighted Average %	Comparison to Benchmarks
Child and Adolescent Well-Care Visits (3-11 Yrs)*	56.72	51.54	51.49	53.34	♦ ♦
Child and Adolescent Well-Care Visits (12-17 Yrs)*	49.68	41.55	42.35	44.54	♦
Child and Adolescent Well-Care Visits (18-21 Yrs)*	27.23	24.1	20.87	23.61	♦
Child and Adolescent Well-Care Visits Total (3-21 Yrs)*	50.89	44.42	44.27	46.53	♦ ♦
Well-Child Visits in the First 30 Months of Life (First 15 Months)*	57.5	57.05	41.13	50.61	♦
Well-Child Visits in the First 30 Months of Life (15-30 Months)*	74.22	71.47	73.49	73.27	♦ ♦

+ ABHWV's HEDIS measure rates reflect performance in all Medicaid populations (MHT and MHP) per NCQA reporting requirements.
* New Measure introduced in MY 2020

Appendix 2 – CAHPS® Survey Measure Results

The CAHPS survey measure tables include 2021 (MY 2020) results for each managed care plan (MCP). The tables also display MCP averages compared to the NCQA Quality Compass Medicaid HMO benchmarks. Results of this comparison are made via a diamond rating system.

NCQA Quality Compass National Medicaid Percentile Ranges	Comparison to Benchmarks
The MCP Average is below the NCQA Quality Compass National Medicaid HMO Average.	♦
The MCP Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75th Percentile.	♦ ♦
The MCP Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid HMO.	♦ ♦ ♦

Adult CAHPS Measures

Adult CAHPS Survey Measures	ABHWV %	THP %	UHP %	MCP Average %	Comparison to Benchmarks
Getting Care Quickly Composite (Always + Usually)	86.87	NA	80.85	83.86	♦
Getting Needed Care Composite (Always + Usually)	87.36	87.30	84.94	86.53	♦ ♦ ♦
How Well Doctors Communicate Composite (Always + Usually)	93.03	95.21	91.73	93.32	♦ ♦ ♦
Customer Service Composite (Always + Usually)	NA	NA	NA	NA	**NC**
Coordination of Care Composite (Always + Usually)	92.38	NA	76.19	84.29	♦
Rating of All Health Care (8+9+10)	79.03	78.42	72.00	76.48	♦
Rating of Personal Doctor (8+9+10)	84.95	87.12	82.91	84.99	♦ ♦
Rating of Specialist Seen Most often (8+9+10)	82.46	NA	77.42	79.94	♦
Rating of Health Plan (8+9+10)	79.46	75.24	73.40	76.03	♦
Flu measure - Had flu shot or spray in the nose since July 1, 2020	41.86	33.33	34.07	36.42	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	70.07	70.83	74.60	71.83	♦

Adult CAHPS Survey Measures	ABHWV %	THP %	UHP %	MCP Average %	Comparison to Benchmarks
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	44.81	45.57	49.59	46.66	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	41.64	38.08	42.11	40.61	♦
NA - Responses <100, too small to calculate a reliable rate NC - No Comparison					

Child CAHPS for General Population (GP)

Child CAHPS Survey Measures	ABHWV %	THP %	UHP %	MHP Average %	Comparison to Benchmarks
Child Survey - General Population: Getting Care Quickly Composite (Always + Usually)	95.21	NA	90.25	92.73	♦ ♦ ♦
Child Survey - General Population: Getting Needed Care Composite (Always + Usually)	93.22	NA	86.12	89.67	♦ ♦ ♦
Child Survey - General Population: How Well Doctors Communicate Composite (Always + Usually)	96.57	98.75	95.75	97.02	♦ ♦ ♦
Child Survey - General Population: Customer Service Composite (Always + Usually)	NA	NA	NA	NA	**NC**
Child Survey - General Population: Coordination of Care Composite (Always + Usually)	87.80	NA	NA	87.80	♦ ♦
Child Survey - General Population: Rating of All Health Care (8+9+10)	89.00	87.39	81.52	85.97	♦
Child Survey - General Population: Rating of Personal Doctor (8+9+10)	89.10	88.40	89.09	88.86	♦
Child Survey - General Population: Rating of Specialist Seen Most often (8+9+10)	NA	NA	NA	NA	**NC**

Child CAHPS Survey Measures	ABHWV %	THP %	UHP %	MHP Average %	Comparison to Benchmarks
Child Survey - General Population: Rating of Health Plan (8+9+10)	87.69	89.89	83.57	87.05	♦ ♦

NA - Responses <100, too small to calculate a reliable rate
NC - No Comparison

Child CAHPS for Children with Chronic Conditions (CCC) Population

Child CAHPS Survey Measures	ABHWV* %	THP %	UHP %	MCP Average %	Comparison to Benchmarks
Child Survey - CCC Population: Family Centered Care - Getting Needed Information (Always + Usually)	93.72	NR	NR	93.72	♦ ♦ ♦
Child Survey - CCC Population: Access to Prescription Medicines	92.55	NR	NR	92.55	♦ ♦
Child Survey - CCC Population: Coordination of Care for Children With Chronic Conditions	81.16	NR	NR	81.16	♦ ♦ ♦
Child Survey - CCC Population: Access to Specialized Services (Always and Usually)	83.20	NR	NR	83.20	♦ ♦ ♦
Child Survey - CCC Population: Family Centered Care - Personal Doctor Who Knows Child	92.80	NR	NR	92.80	♦ ♦ ♦

*ABHWV's Child CAHPS for Children with Chronic Conditions (CCC) Population survey was conducted to target Mountain Health Promise member experiences.
NR - Not Reported; THP and UHP were not required to conduct the CCC survey.