Specialized Managed Care Plan for Children and Youth Program
State Strategy for Assessing and Improving Managed Care Quality

May 31, 2019

Section I: Introduction

Background and Purpose of the Specialized Managed Care Plan for Children and Youth Program

The Specialized Managed Care Plan for Children and Youth is West Virginia's new Medicaid managed care program for children in foster care or the adoption assistance program. The Department of Health and Human Resources (DHHR), hereinafter referred to as the "Department," aims to improve care coordination for medically and socially necessary services to these children and youth.

In the Specialized Managed Care Plan for Children and Youth program, eligible children and youth living across the State of West Virginia will receive their benefits through the specialized managed care organization (MCO) to coordinate services or may disenroll to fee-for-service (FFS). Each enrollee will have a primary care provider (PCP) who will act as their medical home. The medical home promotes better quality, more patient-centered care by providing a continuous source of care that is coordinated and accessible to the member. The medical home concept is central to the Specialized Managed Care Plan for Children and Youth program. The specialized MCO will be responsible for coordinating physical, behavioral, dental, and socially necessary services for each enrolled child.

Specialized Managed Care Plan for Children and Youth Program Management Structure

The Department oversees all aspects of the program, including its quality activities and receives input from several formal and informal groups to support its quality work. The Department will also contract with an external quality review organization (EQRO) to conduct annual, external independent reviews of the quality outcomes associated with, timeliness of, and access to services covered under the MCO Contract. In addition, the Department will coordinate with an advisory group of foster, adoptive, and kinship parents, as outlined within WV State Code Chapter 9, Article 5 to help drive program improvement efforts.

The Department is in frequent contact with numerous stakeholders, including advocates, legislators, providers, other state agencies, the MCO, and the EQRO. These groups will provide feedback on quality activities and programs on an ongoing basis both formally and informally and the Department will regularly engage advocates to provide feedback on a variety of issues, including the Department's Quality Strategy.

Section II: Quality Strategy Approach, Priorities, and Goals

A robust approach to quality is integral to achieving the aims of the **Specialized Managed Care Plan for Children and Youth** program. It ensures that the MCO provides access to high quality care that meets

the program's standards for enrollees. Furthermore, it will coordinate the quality improvement work of the Department and the MCO so that the involved entities will focus on shared priorities, and as a result, make greater quality gains. The Quality Strategy describes the Department's approach to delivering high-quality, accessible care to all enrollees.[1]

Approach

The Quality Strategy employs a three-pronged approach to improving the quality of health care delivered to enrollees in the Specialized Managed Care Plan for Children and Youth program:

1. Monitoring: The Department will monitor the MCO for compliance with its managed care quality standards.
2. Assessment: The Department will analyze a variety of health care data to measure performance and identify focus areas for improvement, including indicators for specific diseases among children and youth.
3. Improvement: The Department and its vendors, including the MCO, implement interventions that target priority areas to maximize the benefit for Specialized Managed Care Plan for Children and Youth enrollees.

This approach allows the Department to drive improvement in key health areas while maintaining the overall quality of the services that are currently being delivered by the Specialized Managed Care Plan for Children and Youth program.

Priorities and Goals

The Quality Strategy outlines five priorities for the Specialized Managed Care Plan for Children and Youth program. The priorities represent broad areas that will support the overarching aim of the managed care program – to provide access to high quality health care for all enrollees. The Department selected priorities that are flexible enough to accommodate changing conditions in the program, while providing a clear path to drive quality improvements.

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

The priorities align with those identified by the National Quality Strategy, which was created under the Affordable Care Act and developed by the US Department of Health and Human Services (DHHS). By coordinating its Quality Strategy with the DHHS National Quality Strategy, DHHR increases the likelihood

[1] Because almost all of the services are expected to be provided to enrollees through the MCO, the Department's Quality Strategy primarily focuses on care delivered by the MCO.

that its quality activities will coordinate with other national, state, or local health care improvement efforts.

Where appropriate, the Department has selected performance measures and improvement goals to correspond with the priorities. These performance measures indicate areas within each priority that the Department and the MCO will focus on improving. The Department chose measures intended to provide the greatest benefit to the enrollees.

Finally, priorities, measures, and goals are associated with specific Department and MCO activities. This will help ensure that the Department and MCO work is supporting quality improvement. The activities are described in greater detail throughout the Quality Strategy. By aligning these priorities, measures, and activities and setting achievable goals the Quality Strategy will drive quality improvement in the program.

Table 1 outlines the structure of the Quality Strategy as described above. The five priorities are listed in the top row of the table. The corresponding measures, goals, and activities and interventions are listed in the column below each priority. Additional measures and goals shall be identified through stakeholder engagement as the program matures over the course of the first waiver period.

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

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

Section III: Development and Review of the Quality Strategy

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

Initial Development

The Department reviewed the managed care program goals, the National Quality Strategy[2], and those defined by Chapter 49 of WV State Code to develop broad quality priorities that would be flexible to changing conditions within and outside of the Specialized Managed Care Plan for Children and Youth program.

The Department chose measures using the following criteria:

- Relevance to the core populations served by the MCO
- Number of members for which the measure is applicable
- Alignment with priority chronic diseases, including asthma, diabetes, and obesity
- Alignment with existing Department quality improvement activities
- Alignment with the Governor of West Virginia's statewide goals
- Inclusion in the core set of quality measures for children and youth in Medicaid and CHIP, a set of priority measures selected by the US Department of Health and Human Services and developed by leading quality organizations, including the National Committee for Quality Assurance (NCQA)
- The NCQA reported national MCO performance benchmarks
- Whether the measure examines care processes, rather than health outcomes (*children may only be enrolled in the managed care program for a short period of time, so it can be difficult for the MCO to substantially affect the health statuses of enrollees*)

The Department will work with its newly procured EQRO to determine reasonable, achievable improvement goals for the selected measures.

Stakeholder Input

The Department currently holds monthly child welfare stakeholder meetings that are open to the public. The state shares information about the MCO model, as well as other child welfare reform initiatives, and receives input from stakeholders. Once the MCO delivery system is implemented the MCO will also be required to create a voluntary advisory group of foster, adoptive, and kinship parents, which must meet every quarter for the first year and then every six (6) months thereafter, to discuss issues they are

[2] https://www.ahrq.gov/workingforquality/about/nqs-fact-sheets/fact-sheet.html

encountering with the MCO and recommend solutions. This feedback will inform the Department's quality strategy.

Review

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

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

The Department will submit a copy of the strategy to the Centers for Medicare and Medicaid Services (CMS) whenever substantial changes are made and will submit reports on the implementation and effectiveness of the strategy as required.

Section IV: State Standards

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

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

Table 2: Methods for Determining Compliance with Quality Standards

Prospective Methods	• Department MCO certification via desk and site reviews. • MCO contracts with the State of West Virginia • Department review of MCO provider network • West Virginia State Insurance Commission MCO licensing
Concurrent Methods	• Review of quarterly reports and encounter data
Retrospective Methods	• Annual external quality review, including validation of performance improvement projects, validation of performance measures, and compliance review • Annual review of HEDIS® and CAHPS results • Review of monthly encounter data and annual reports • Quarterly review of complaint, grievance, and appeals filings

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

Access Standards

Availability of Services (§438.206)

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

The Department ensures, through its contracts, that the MCO meets the requirements shown in the table below. The MCO is required to submit quarterly assurance of adequacy through a PCP panel and specialist availability report. On an annual basis, the Department requires the MCO to submit its full provider networks for re-evaluation. The Department measures and compares the networks against established FFS benchmarks.

Availability of Services Requirement	Regulatory Citation	MCO Contract Reference
a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract, considering the following: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO. • The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. • The numbers of network providers who are not accepting new Medicaid patients. • The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.	§438.206(b)(1)	Article III, Section 3.1.1
b. Provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	§438.206(b)(2)	Article III, Section 3.1.3
c. Provide for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	§438.206(b)(3)	Article III, Section 6.1
d. If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the MCO is unable to provide them.	§438.206(b)(4)	Article III, Section 6.2
e. Require out-of-network providers to coordinate with the MCO with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.	§438.206(b)(5)	Article III, Section 6.2

Availability of Services Requirement	Regulatory Citation	MCO Contract Reference
f. Demonstrate that its providers are credentialed.	§438.206(b)(6)	Article III, Section 3.1.5
g. Demonstrate that the network includes sufficient family planning providers to ensure timely access to covered services.	§438.206(b)(7)	Article III, Section 2.2.6
h. Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.	§438.206(c)(1)(i)	Article III, Section 3.1.2
i. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.	§438.206(c)(1)(ii)	Article III, Section 3.1.2
j. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	§438.206(c)(iii)	Article III, Section 3.1.2
k. Establish mechanisms to ensure compliance by providers.	§438.206(c)(iv)	Article III, Section 3.1.2
l. Monitor providers regularly to determine compliance.	§438.206(c)(v)	Article III, Section 3.1.2
m. Take corrective action if there is a failure to comply.	§438.206(c)(vi)	Article III, Section 3.1.2
n. Participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.	§438.206(c)(2)	Article III, Section 3.1.2
o. Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	§438.206(c)(3)	Article III, Section 3.1.2

Assurances of Adequate Capacity and Services (§438.207)

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

After the Department reviews the documentation submitted by the MCO, the Department will certify to CMS that the MCO has complied with the Department's requirements for availability of services. The submission to CMS will include documentation of an analysis that supports the assurance of the adequacy of the network for each MCO. The Department will make available to CMS, upon request, all documentation collected by the Department from the MCO.

Requirement	Regulatory Citation	MCO Contract Reference
a. Submit documentation to the Department, in a format specified by the Department to demonstrate that it complies with the following requirements: • Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area. • Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	§438.207(b)	Article III, Section 3.1
b. Submit the documentation described in paragraph (b) of this section as specified by the Department, but no less frequently than the following: • At the time it enters into a contract with the Department. • At any time there has been a significant change (as defined by the Department) in the MCO's operations that would affect adequate capacity and services, including-- o Changes in MCO services, benefits, geographic service area or payments; or o Enrollment of a new population in the MCO.	§438.207(c)	Article III, Section 3.1

Coordination and Continuity of Care (§438.208)

The Department ensures through its contracts that each MCO complies with the requirements regarding coordination and continuity of care, including procedures to deliver primary care to and coordinate health care services for all MCO enrollees as well as assess Medicaid enrollees identified as having special health care needs. The Department ensures that the MCO meets the requirements shown in the table below.

The Department has mechanisms to identify persons with special health care needs, defined as individuals with complex or serious medical conditions and who also require health and related services of a type or among beyond that required generally.

As stated in the Department's Purchase of Service Provider Agreement with the MCO for A Specialized Managed Care Plan for Children and Youth, hereinafter referred to as "the MCO Contract", the MCO must have procedures in place for identifying children and youth with special health needs. The MCO shall use appropriate health care professionals in assessing those conditions, identifying medical procedures to address and/or monitor these conditions, and developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring. The treatment plan must be developed by the enrollee's primary care provider with participation from

the enrollee and in consultation with any specialists caring for the enrollee and shall meet applicable quality assurance and utilization standards. The MCO approves the treatment plan as expeditiously as the enrollee's health condition requires. These treatment plans must be time-specific and updated periodically by the primary care provider. Furthermore, the MCO must have mechanisms in place to follow-up with enrollees that do not adhere to their treatment plans.

Requirement	Regulatory Citation	MCO Contract Reference
a. Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. The enrollee must be provided information on how to contact their designated person or entity.	§438.208(b)(1)	Article III, Section 6.3
b. Coordinate the services the MCO furnishes to the enrollee: • Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; • With the services the enrollee receives from any other MCO; • With the services the enrollee receives in FFS Medicaid; and • With the services the enrollee receives from community and social support providers.	§438.208(b)(2)	Article III, Section 6.3
c. Provide that the MCO makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.	§438.208b(3)	Article III, Section 6.8
d. Share with other MCOs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.	§438.208(b)(4)	Article III, Section 6.6.3
e. Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.	§438.208(b)(5)	Article III, Section 6.8
f. Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	§438.208(b)(6)	Article III, Section 6.3
g. Implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.	§438.208(c)(2)	Article III, Section 6.3.1

Requirement	Regulatory Citation	MCO Contract Reference
h. For enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan produced by the MCO must be: • Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly or at the request of the enrollee; • Approved by the MCO in a timely manner, if this approval is required by the MCO; and • In accord with any applicable State quality assurance and utilization review standards.	§438.208(c)(3)	Article III, Section 6.3.1
i. Have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs (for enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring).	§438.208(c)(4)	Article III, Section 6.3.1

Coverage and Authorization of Services (§438.210)

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

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

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

Requirement	Regulatory Citation	MCO Contract Reference
c. May place appropriate limits on a service: • On the basis of criteria applied under the State plan, such as medical necessity; or • For the purpose of utilization control, provided that o The services furnished can reasonably be expected to achieve their purpose; o The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and o Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.	§438.210(a)(4)	Article III, Section 6.4
d. Specify what constitutes ``medically necessary services'' in a manner that: • Is no more restrictive than that used in the Department Medicaid program as indicated in State statutes and regulations, the Department Plan, and other State policy and procedures; and • Addresses the extent to which the MCO is responsible for covering services related to the following: o The prevention, diagnosis, and treatment of health impairments. o The ability to achieve age-appropriate growth and development. o The ability to attain, maintain, or regain functional capacity.	§438.210(a)(4)	Article II, Section 1
e. Have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorizations of services.	§438.210(b)(1)	Article III, Section 6.4
f. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate.	§438.210(b)(2)	Article III, Section 6.4
g. That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	§438.210(b)(3)	Article III, Section 6.4
h. Notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 438.404.	§438.210(c)	Article III, Section 6.4

Requirement	Regulatory Citation	MCO Contract Reference
i. Provide notice for standard authorization decisions as expeditiously as the enrollee's health condition requires and within State-established timeframes of 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if: • The enrollee, or the provider, requests extension; or • The MCO justifies (to the Department upon request) a need for additional information and how the extension is in the enrollee's interest.	§438.210(d)(1)	Article III, Section 4.8
j. For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service. The MCO may extend the 3 working days' time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the Department upon request) a need for additional information and how the extension is in the enrollee's interest.	§438.210(d)(2)	Article III, Section 6.4
k. Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	§438.210(e)	Article III, Section 6.4

Structure and Operation Standards

Provider Selection (§438.214)

The Depatment ensures through its contracts that each MCO implements written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, the requirements of the regulation. The Department has established a uniform credentialing and recredentialing policy that the MCO must follow and ensures that the MCO meets the requirements shown in the table below. Detailed MCO credentialing requirements are contained in Article III of the MCO Contract.

Requirement	Regulatory Citation	MCO Contract Reference
a. Follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO.	§438.214(b)(2)	Article III, Section 3.1.5

Requirement	Regulatory Citation	MCO Contract Reference
b. Must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	§438.214(c)	Article III, Section 3.1.4
c. May not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	§438.214(d)	Article III, Section 3.1.4
d. Must comply with any additional requirements established by the Department.	§438.214(e)	Article III, Section 3.1.5

Enrollee Information (§438.218)

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

Confidentiality (§438.224)

The Department ensures through its contracts that the MCO uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. The MCO Contract contains requirements that are consistent with 42 CFR Part 431 Subpart F.

Enrollment and Disenrollment (§438.226)

The Department ensures through its contracts that each MCO complies with the enrollment and disenrollment requirements and limitations. The MCO Contract contains requirements that are consistent with 42 CFR 438.56.

Grievance Systems (§438.228 and §438.416)

The Department ensures through its Contract that the MCO has in effect a grievance system that meets the requirements of 42 CFR Part 438 Subpart F. Detailed MCO grievance requirements are contained in the MCO Contract Scope of Work. The State requires the MCO to maintain records of grievances and appeals and reviews this information through the MCO quarterly reporting process, as required in the MCO Contract. The State reviews the grievances and appeals report each quarter and, in conjunction with the EQRO, conducts annual audits of the grievances and appeals reports and MCO processes to ensure compliance with regulations and timeframes.

The Department delegates to the MCO responsibility for notice of action under Subpart E of Part 431 of this chapter. The Department or its contractor reviews or audits each

delegated MCO and its providers and subcontractors to ensure that they are notifying enrollees and providers in a timely manner.

Subcontractual Relationships and Delegation (§438.230)

The Department ensures through its Contract that the MCO complies with requirements regarding subcontractual relationships and delegation. Detailed MCO delegation requirements are contained in the MCO Contract Scope of Work.

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

Measurement and Improvement Standards

Practice Guidelines (§438.236)

The Department ensures through its Contract that each MCO complies with requirements regarding practice guidelines. Detailed MCO practice guidelines requirements are contained in the MCO Contract Scope of Work.

Requirement	Regulatory Citation	MCO Contract Reference
a. Adopt practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the MCO's enrollees. • Are adopted in consultation with contracting health care professionals. • Are reviewed and updated periodically as appropriate.	§438.236(b)	Article III, Section 6.7
b. Disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	§438.236(c)	Article III, Section 6.7
c. Ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	§438.236(d)	Article III, Section 6.7

Quality Assessment and Performance Improvement Program (§438.330)

The Department ensures through its contracts that the MCO has an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. Detailed MCO quality assessment and performance improvement requirements are contained in the MCO Contract Scope of Work.

If CMS, in consultation with states and other stakeholders, specifies performance measures and topics for performance improvement projects to be required by states in their contracts with MCOs, the Department will incorporate these performance measures and topics into the Quality Assurance and Performance Improvement (QAPI) program requirements.

The Department will review, at least annually, the impact and effectiveness of the MCO's quality assessment and performance improvement program. The review will include the MCO's performance on the standard measures on which it is required to report and the results of the MCO's performance improvement projects. The Department requires that the MCO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

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

Requirement	Regulatory Citation	MCO Contract Reference
a. Conduct performance improvement projects. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.	§438.330(b)(1)	Article III, Section 7.2
b. Collect and submit performance measurement data.	§438.330(b)(2)	Article III, Section 7
c. Have in effect mechanisms to detect both underutilization and overutilization of services.	§438.330(b)(3)	Article III, Section 7
d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	§438.330(b)(4)	Article III, Section 7
e. Perform a combination of the following activities: • Measure and report annually to the Department its performance, using standard measures required by the Department • Submit to the Department data, specified by the Department, which enables the Department to calculate the MCO's performance using the standard measures identified by the Department	§438.330(c)(2)	Article III, Section 7.3
f. Have an ongoing program of performance improvement projects that are designed to achieve significant improvement in health outcomes and enrollee satisfaction, and that involve the following: • Measurement of performance using objective quality indicators. • Implementation of system interventions to achieve improvement in access to and quality of care. • Evaluation of the effectiveness of the interventions. • Planning and initiation of activities for increasing or sustaining improvement.	§438.330(d)(2)	Article III, Section 7
g. Report the status and results of each project to the Department as requested, but not less than once per year. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.	§438.330(d)(3)	Article III, Section 7

Health Information Systems (§438.242)

The Department ensures, through its Contract, that the MCO maintains a health information system that collects, analyzes, integrates, and reports data and can achieve

the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. The Department will review and validate that the encounter data collected, maintained, and submitted by the MCO meets the requirements below. The Department must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted is a complete and accurate representation of the services provided to the enrollees under the contract between the Department and the MCO. The requirements for MCO health information systems are contained in the MCO Contract Scope of Work.

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

Requirement	Regulatory Citation	MCO Contract Reference
a. Collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Department to meet the requirements of section 1903(r)(1)(F) of the Act.	§438.242(b)(1)	Article III, Section 7.4
b. Collect data on enrollee and provider characteristics as specified by the Department, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the Department.	§438.242(b)(2)	Article III, Section 7.4
c. Ensure that data received from providers is accurate and complete by: • Verifying the accuracy and timeliness of reported data; • Screening the data for completeness, logic, and consistency; and • Collecting service information in standardized formats to the extent feasible and appropriate.	§438.242(b)(3)	Article III, Section 7.4
d. Make all collected data available to the Department and upon request to CMS, as required.	§438.242(b)(4)	Article III, Section 7.4
e. Collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.	§438.242(c)(1)	Article III, Section 6.11.5
f. Submit enrollee encounter data to the Department at a frequency and level of detail to be specified by CMS and the Department, based on program administration, oversight, and program integrity needs.	§438.242(c)(2)	Article III, Section 6.11.5
g. Submit all enrollee encounter data that the Department is required to report to CMS under § 438.818	§438.242(c)(3)	Article III, Section 6.11.5
h. Submit encounter data to the Department in standardized ASC X12N 837 and NCPCP formats, and the ASC X12N 835 format as appropriate.	§438.242(c)(4)	Article III, Section 6.11.5

Section V: Assessment

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

The Department uses several methods to assess the quality of care being delivered by the MCO, including the following:

- Evaluation of the quality and appropriateness of care: the Department has procedures in place to ensure that high quality, appropriate care is delivered to all enrollees, including those with special health care needs, regardless of their race, ethnicity, and primary language spoken.
- Performance measurement: The Department requires the MCO to collect and report measures from the HEDIS® and the CAHPS surveys.
- External quality review: the Department contracts with an EQRO to conduct independent evaluations of MCO performance, in accordance with federal regulations.
- MCO reports: the MCO is required to submit several reports to the Department, which allows the Department to monitor MCO quality.

Quality and Appropriateness of Care

The Department has established a written quality strategy for assessing and improving the quality of health care and services furnished to all Medicaid enrollees under the MCO Contract as required by 42 CFR §438.340. Many of these procedures are performed by the EQRO.

In accordance with 42 CFR §438.340(b)(6), the Department will identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. Once this demographic information for each Medicaid enrollee is identified, the Department will provide it to the MCO at the time of enrollment. The Department collects information on the race, ethnicity, and primary language spoken of each Medicaid enrollee at the time of initial determination of Medicaid eligibility and enters the data into the State's eligibility system, RAPIDS. This information is then sent to the MCO through a Health Insurance Portability and Accountability Act (HIPAA) compliant transmission.

The Department has additional procedures in place to ensure that children and youth with special health care needs receive quality, appropriate care. These procedures are also described in the Section IV of this document.

Performance Measurement

Performance measurement is key to monitoring and improving quality. It allows the Department to understand the quality of care currently being delivered to enrollees and evaluate MCO performance overtime. Therefore, the Department requires the MCO to calculate and report a variety of performance measures as specified in the MCO contract.

Most importantly, the Department requires the MCO to report HEDIS® and CAHPS measures, which indicate the quality of care delivered by and enrollee satisfaction with the program. More specifically, the MCO must collect and report measures in the following areas:

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

External Quality Review (EQR)

The Department contracts with an EQRO to conduct annual, external, independent reviews of the timeliness of, access to, and quality outcomes related to the services covered under the MCO Contract.

The EQR activities provide the Department with important information about MCO performance, including whether the MCO is meeting the access, structure and operations, and measurement and improvement standards required by the MCO contract. They also ensure MCO quality measurement and improvement activities are being conducted in accordance with industry standards.

<u>EQR Review Process</u>

The operational systems compliance review is conducted by a team of EQRO analysts and clinicians who conduct an on-site evaluation and review MCO documentation on the MCO's processes for quality assurance, enrollee information, utilization management, credentialing, enrollee rights, health education, and fraud and abuse. The validation activities for the performance improvement projects and the performance measures are conducted according to the CMS-approved protocols and the NCQA HEDIS® audit methodology.

Upon completion of the external review, the EQRO develops and submits a detailed report of findings and recommendations for quality improvement to the Department and the MCO. Quality improvement plans are developed by the MCO for each component of

the external review that does not meet the minimum required standards set forth in the MCO Contract or that resulted in any quality concerns. The quality improvement plans must address timelines and corrective action steps for remediation of the quality concern. The Department monitors corrective action plans on a quarterly basis to ensure that the MCO is addressing all areas identified as needing improvement.

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

Duplication of Standards

As allowed by the CMS "non-duplication" regulation (42 CFR §438.360), the EQRO contractor will review the Medicare and Medicaid standards for instances where structural and operational standards overlap between the Medicare review and the EQR Medicaid review (such as credentialing and recredentialing procedures, using practice guidelines, reporting processes to the MCO Board of Directors, approval of the Quality Improvement Committee). In these cases, the EQRO will base its reporting on the Medicare findings to avoid duplication. For example, because the credentialing and recredentialing procedures used for Medicare and Medicaid are the same and the process used by Medicare for review of provider credentialing is substantially the same as that used by the EQRO for Medicaid, the EQRO would use the Medicare review for the requirements that are the same. The MCO will continue to be subject to EQRO review of those activities that are unique to the Medicaid program, such as review of grievance and appeals processes, timelines, notifications regarding state fair hearing processes, and EPSDT outreach and notices. The State and the EQRO will monitor, on an ongoing basis, the Medicare standards and processes for review to determine where it is appropriate to use the Medicare review to avoid duplication.

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

MCO Reports

The MCO is required to submit annual, monthly, quarterly, and periodic reports to the Department as described in the MCO Contract. These reports provide information that allows the Department to monitor the MCO.

Monthly Reports

The MCO is required to submit monthly reports that summarize information from the previous month and must be submitted to the Department by the 15th of the following month to which they apply. This allows the Department to monitor quality and fraud and abuse activities to identify issues quickly. The MCO will be required to submit reports on the following:

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

Quarterly Reports

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

- Medicaid enrollment and membership
- Children with special health care needs
- Provider access and availability (PCP and specialist)
- Grievances and appeals
- Utilization of health care services
- Member and provider services functions
- Financial performance
- EPSDT services

Periodic Reports

The MCO must provide the Department with uniform data on a regular basis, as described in the MCO Contract. These include the following reports:

- Enrollment composition
- Member satisfaction

- HEDIS® performance
- Financial performance
- Required reportable diseases

Annual Reports

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

Section VI: Improvement and Interventions

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

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

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

Quality Improvement Programs

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

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

Performance Improvement Projects

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

The MCO is required to have three PIPs in place. The MCO must also run its own PIP project, which allows them to focus on the needs of its specific enrolled population.

NCQA Accreditation

West Virginia has a history of requiring MCO accreditation by NCQA; beginning in 2014, all MCOs were required to be accredited by NCQA. NCQA has a rigorous accreditation process and its standards support continuous quality improvement. This accreditation requirement enhances the Department's oversight of MCO administration by adding an additional layer of review. It will also reduce some of the burden associated with EQR compliance reviews.

Intermediate Sanctions

The State contract establishes intermediate sanctions under certain circumstances as required by 42 CFR 438.700. The State contract awards the MCO due process protections including a notice of sanction (42 CFR 438.710). The State contract informs the MCO that the State must notify CMS of any sanctions imposed (42 CFR 438.724). In addition, the State retains authority to impose additional sanctions at its discretion under State statutes or State regulations (42 CFR 438.702(b)). The State exercises this authority by monitoring the following key dimensions to determine areas of the potential non-performance:

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

The following remedies are currently incorporated under the MCO contract:

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

Section VII: Health Information Technology

A strong health information technology system drives quality improvement by supporting quality monitoring, assessment, and improvement activities. The Department has an

information system that aids initial and ongoing operation and review of the Quality Strategy. The information system includes the Medicaid eligibility and claims/expenditures systems, the Medicaid managed care enrollment system, and the encounter data system. Each system component is described in more detail below:

- Medicaid eligibility and claims/expenditure systems. The Medicaid eligibility system provides data that is used to determine which Medicaid beneficiaries are eligible for enrollment in the program. The eligibility and claims systems are used to ensure that fees for carved-out services for enrollees are paid appropriately. These systems provide information that is used in the rate-setting process. Data from the eligibility and claims systems are also used to provide comparison information on the Medicaid fee-for-service system which is used by the State to evaluate the performance of the program as part of ongoing quality monitoring efforts.
- Medicaid managed care enrollment system. The managed care enrollment system is maintained by the contracted enrollment broker and linked to the State's Medicaid Management Information System (MMIS). The enrollment information system includes information on past and currently-enrolled beneficiaries, including current and past MCO assignments and current primary care provider assignments. The enrollment system tracks reasons for disenrollments and plan switches. As noted above, the State collects and shares with the MCO information on the race, ethnicity, and primary language spoken for each Medicaid enrollee.
- Encounter data system. The encounter data system exchanges information between the eligibility and claims systems. The MCO is required to submit encounter data for all defined benefit package services rendered monthly, no later than 90 calendar days after the end of the quarter in which the encounters occurred. All encounters are submitted in electronic or magnetic format, consistent with the formats and coding conventions of the CMS 1500 and UB04. The Department reviews all encounter data for timeliness and usability and performs longitudinal analysis to make sure that the data are complete and accurate. The analysis uses HEDIS® measure definitions corresponding to the year of data, where possible, to ensure consistency and comparability to other encounter data studies.

Specifically, each of the components in the information system provides the State with an "early warning system" to monitor general quality throughout the Medicaid managed care program. Medicaid eligibility is determined and maintained by the Department. The eligibility system identifies the race, ethnicity, and primary language of each enrollee, which the State provides to the MCO. The managed care enrollment fields are updated and maintained by the enrollment broker. The enrollment broker tracks reasons for provider changes and plan disenrollment, which can be signals of enrollee dissatisfaction.