Managed Care in WV

DHHR's Path Forward

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September 2015

WEST VIRGINIA Department of Health & Human Resources

Agenda

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1. **WV Population Health**
2. **DHHR and Medicaid Budget Overview**
3. **DHHR Strategy Moving Forward**
4. **Committee Questions on Managed Care**

West Virginia
Population Health

WV Risk Factor Indicators

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Risk Factor	WV Prevalence	Rank	U.S. Prevalence
Current Smoking	27.3%	1	18.1%
Smokeless Tobacco Use	9.4%	1	3.7%
Obesity	35.1%	1	28.3%

West Virginia ranks among the bottom in America's Health Rankings.

Data Source: WV Health Statistics Center, Behavioral Risk Factor Surveillance System, 2013

WV Behavioral Health Statistics

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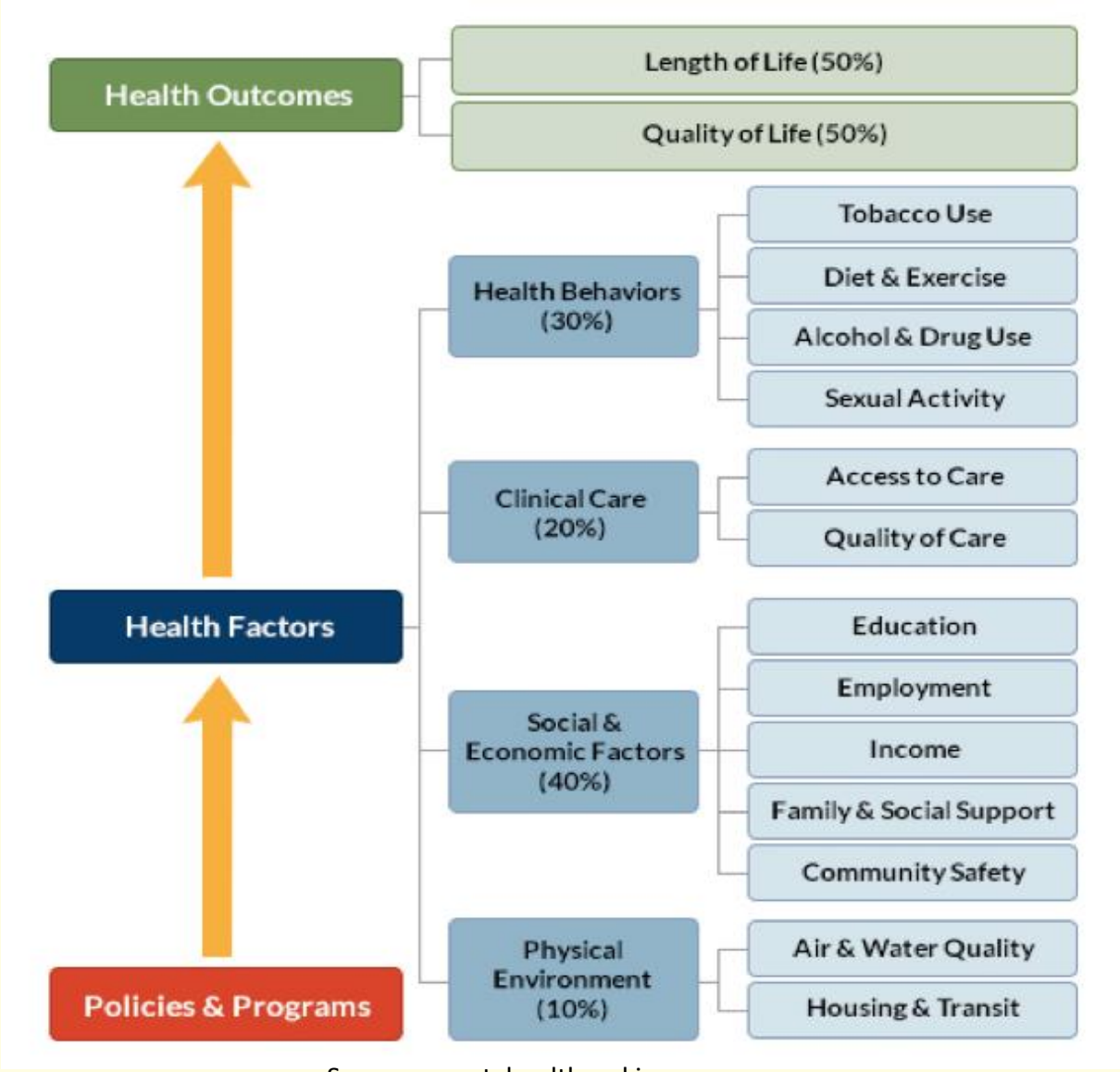
Cause of Death	WV Prevalence Rank Nationally
Severe Mental Illness	1
Poor Mental Health Days (unable to function)	1
Prescriptions for Controlled Substances	1
Drug Induced Deaths	1
Any Mental Illness	3
Major Depressive Episode	5
Suicide	7

Data Sources:

- *WV Health Statistics Center, Vital Statistics System, 2013*
- *SAMSHA*
- *NAMI*

Determinants of Health

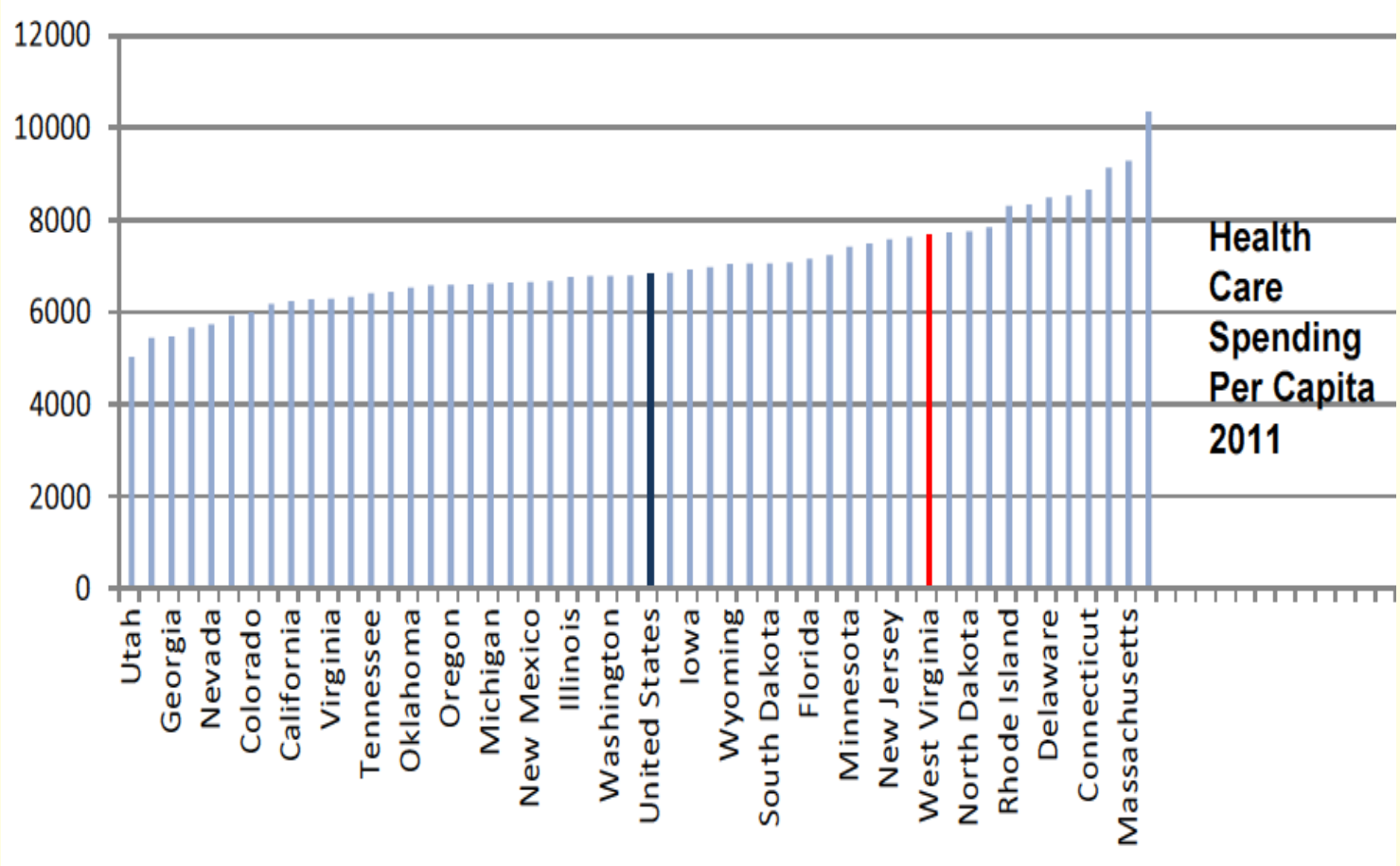


Source: countyhealthrankings.com

DHHR and Medicaid Budget

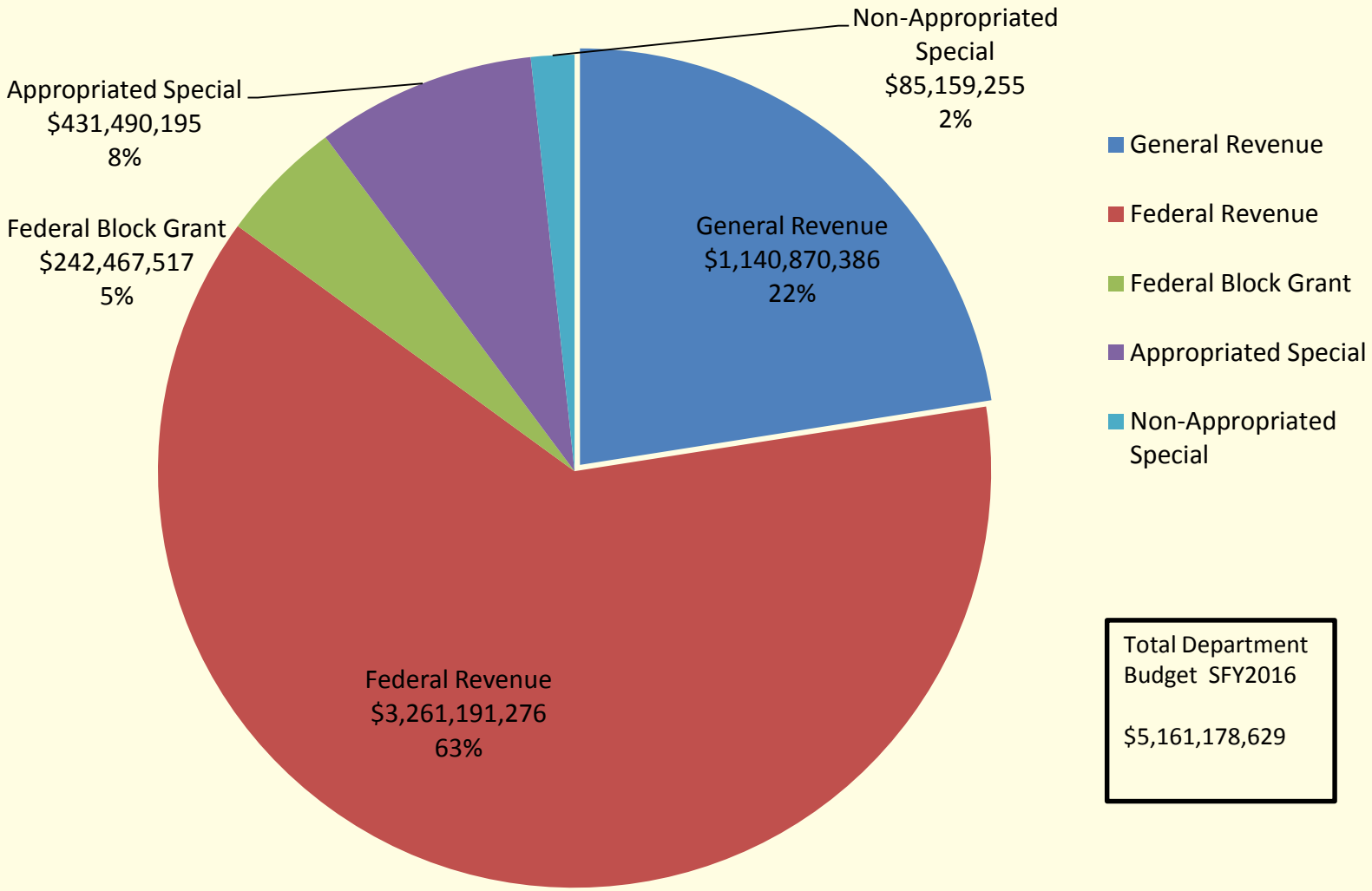
Return on Investment?

- West Virginia ranks 12th in per capita health care spending and 44th in overall health outcomes



Source: http://kff.org/other/state-indicator/health-spending-per-capita/
Source: http://www.americashealthrankings.org/WV

DHHR Budget by Funding Source SFY2016

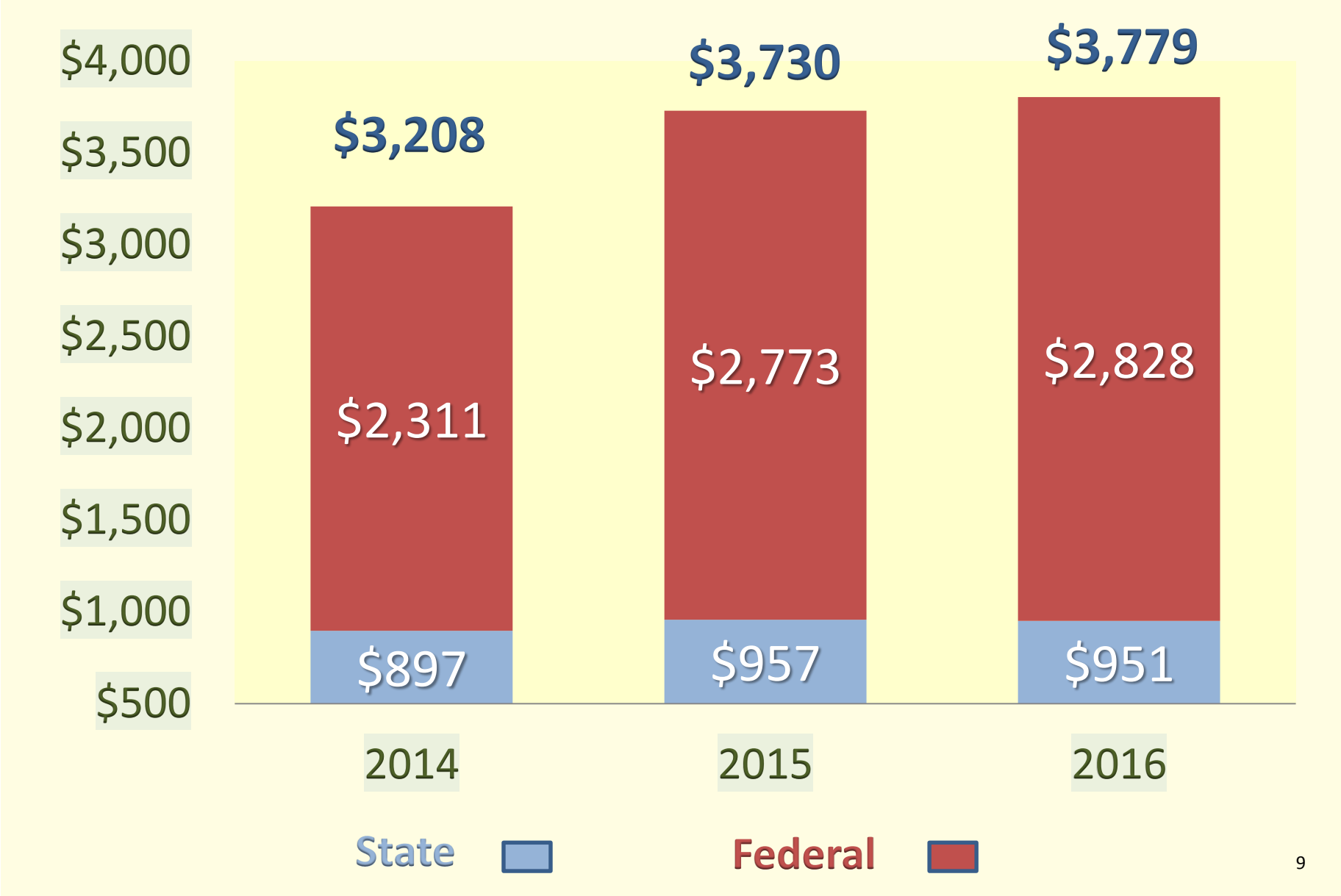


Total Department Budget SFY2016

$5,161,178,629

Source: 2015 DHHR Budget Presentation to Legislature

Medicaid Medical Costs (in millions)



Source: 2015 DHHR Budget Presentation to Legislature

Committee Questions on Managed Care

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DHHR Privatization Strategy

What is Fee for Service?

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- Some Medicaid enrollees are served through a fee-for-service delivery system where health care providers are paid for each service (like an office visit, test, or procedure).
- Under a fee-for-service model (FFS), patients seek services from any contracted provider who then bills the state for services rendered.
- The FFS model is an unstructured system of care that may incentive higher claim volumes amongst some providers.
- FFS results in segregated care for consumers.

Source: CMS- http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

What is Managed Care?

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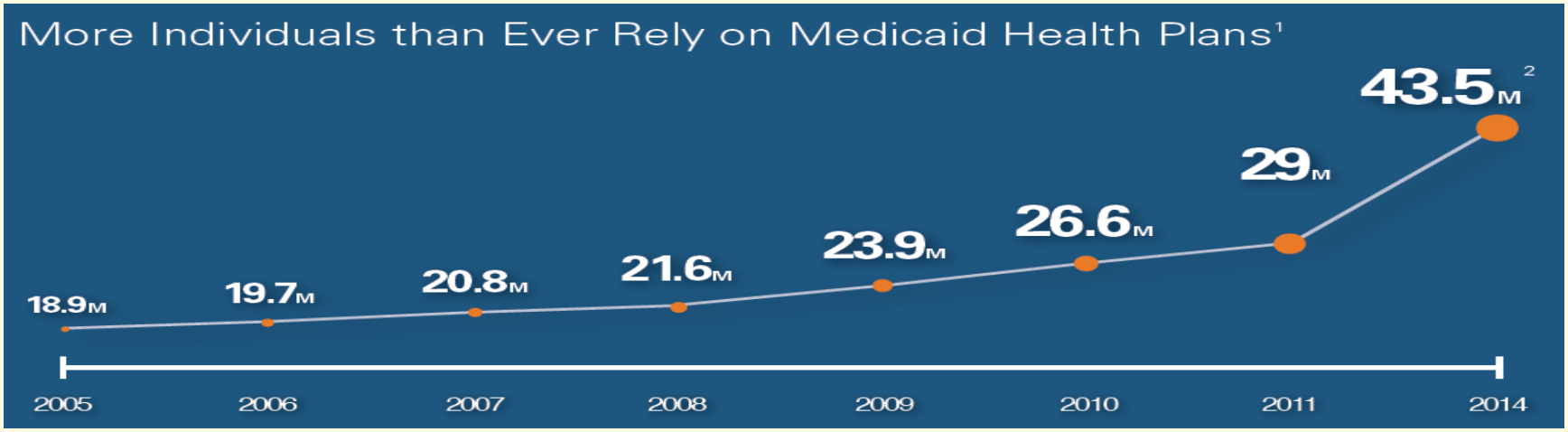
- Managed Care is a health care delivery system organized to manage cost, utilization, and quality.
- Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.
- These arrangements result in the transfer of risk from the state to the MCO.
- By contracting with MCOs to deliver health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.
- Nationally, CMS states approximately 80% of Medicaid enrollees are served through managed care delivery systems.

Source: CMS- http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

What is Managed Care?

- Managed care is a proven strategy for cost savings for states.
- Nationally, managed care outperforms fee-for-service programs on key quality measures and recent research has shown that by coordinating medical and pharmacy benefits, Medicaid health plans saved $2.06 billion in expenditures in 2014 alone (up to 20%).



Source: America's Health Insurance Plans- http://ahip.org/Issues/Medicaid-Health-Plans.aspx

Other States and Managed Care

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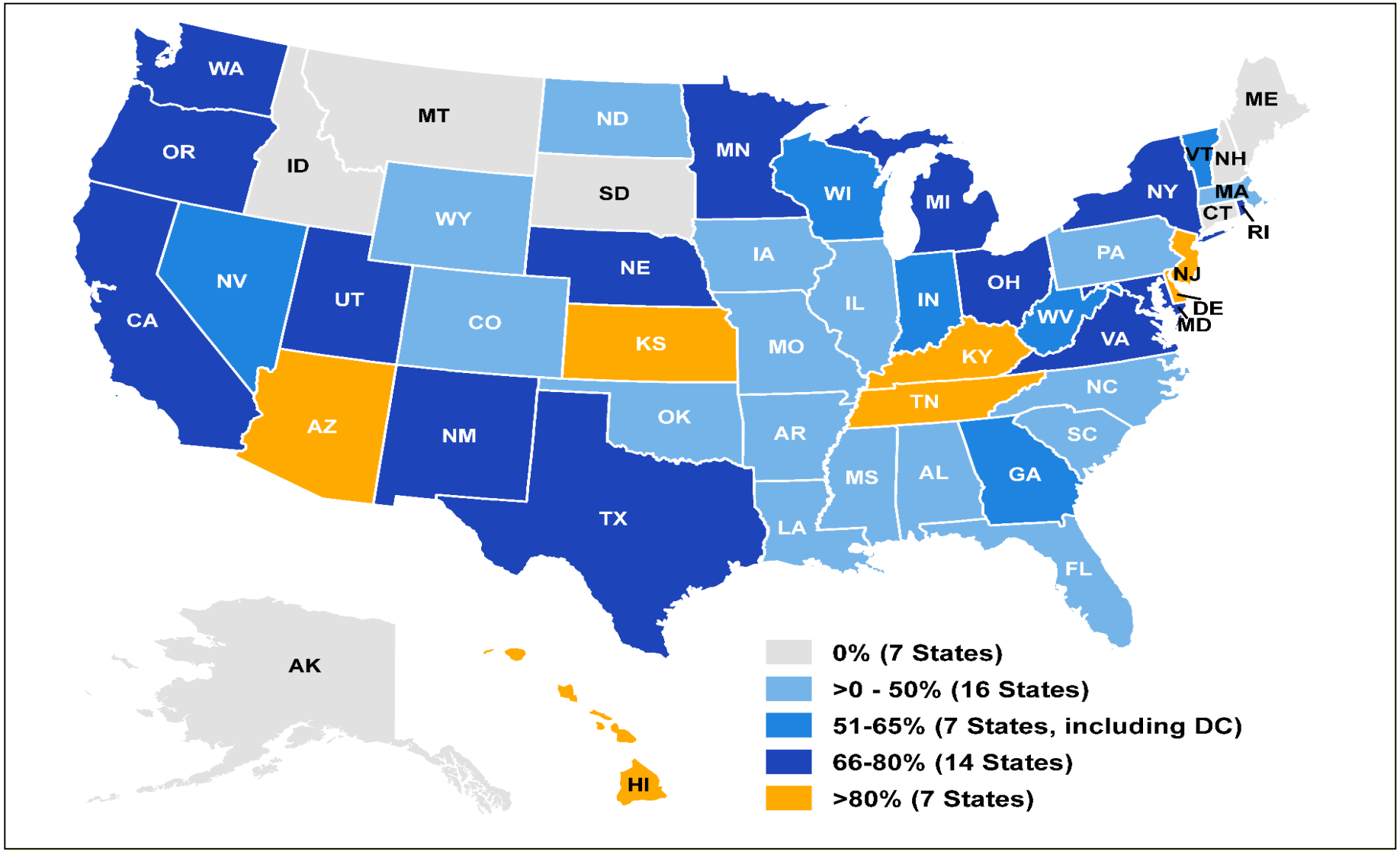
- Ohio Governor John Kasich is moving Medicaid to managed care (including behavioral health), as one of his administration's major budget reduction initiatives to save tax payer dollars.
- Kansas Governor Sam Brownback, to address budgetary issues, moved almost all Medicaid recipients into managed care two years ago — a program called KanCare.
- Kentucky Governor Steve Beshear has been granted MCO waivers for statewide reform initiatives to improve quality care and cut costs.
- According to CMS, only seven states have no form of managed care.

Source:
State of Ohio: http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=7RkwqMIrH8U%3D&tabid=252
State of Kansas: http://www.kdheks.gov/hcf/medicaid_reform_forum/download/KanCare_Executive_Summary.pdf
State of KY: http://http://medicaidmc.ky.gov/Pages/news.aspx
CMS: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-medicaid-managed-care-enrollment-report.pdf

Other States and Managed Care



Source: CMS- http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-medicaid-managed-care-enrollment-report.pdf

Managed Care in West Virginia

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- The West Virginia Bureau for Medical Services (BMS) initiated a risk-based managed care program for certain populations in September 1996.
- To operate a managed care program, WV must first obtain waiver approval from the federal government.
- WV manages the Medicaid program with a Section 1915(b) Capitated Waiver.
- The program operates under the name Mountain Health Trust.
- Before submission of waiver amendments to CMS, the waiver is taken before the Medicaid Services Fund Advisory Council and is subject to a public comment period.
- The managed care waiver can be found on the BMS website under the Mountain Health Trust section.

Source: http://www.dhhr.wv.gov/bms/Public%20Notices/Documents/LEWINVA-571041-v1-WV_1915b_Waiver_Amendment_WVFH_Expansion_7-15%20(2).pdf

History of Managed Care in WV

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- Historically, the Mountain Health Trust program has operated enrollment predominantly for TANF-related children and caretaker adults, pregnant women, and transitional Medicaid populations.
- The program has historically covered only select medical services.
- Before 2013, the following benefits were carved out of managed care:
  - Dental
  - Pharmacy
  - Behavioral Health

Managed Care Process

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- Each year a contract is signed by any participating MCO and reviewed by CMS to ensure federal compliance
- Each year, independent actuaries develop a capitation rate range (approximately 350 individual rates)
- New claim experience is used as the basis to set actuarially sound capitation rates, so when it is observed that the MCOs are curbing unnecessary utilization of services this will decrease future capitation rates and save WV Medicaid even more money
- Starting in 2014, DHHR directed the actuaries to place the rate at bottom of the range to ensure more state savings
- CMS must review these rates to ensure they are actuarial sound
  - Two offices within CMS review the rates, including the federal Office of the Actuary. CMS also contracts with an independent third party actuary to review the rates.

DHHR Attempting to Procure MCO Contracts

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- On June 16, 2015, the WV Supreme Court stayed an injunction regarding the FY2016 Medicaid managed care contracts.
- With the healthcare for nearly one third of West Virginians and the state's budget at stake, DHHR has been diligently reviewing this matter to determine if it can be resolved quickly without harming the State or its most vulnerable citizens.
- To end the uncertainty that the litigation has caused, DHHR is seeking to competitively bid the FY17 Medicaid managed care contracts in accordance with an RFP DHHR has submitted to the Department of Administration.
- This submission should not be construed as an admission of fault or oversight by DHHR. Rather, DHHR is submitting the RFP solely to resolve this matter to avoid further harming WV Medicaid beneficiaries.
- If these contracts can be procured, approved rates will be set, and actuarial review will take place as necessary and approved by CMS before contracts are finalized.

Benefits of Managed Care Privatization

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- **Saves taxpayer dollars**
- **Improves care coordination for consumer**
- Capitated risk transference provides the state with a level of financial predictability not available in FFS model.
- As waiver program, MCOs have more flexibility from federal government regulations
- MCOs are better positioned to manage care of patients and relationships with providers than state government
- MCOs have market incentives that do not exist in government managed process that drive savings
- MCOs have resources not available to state that can adjust to shifts in market from innovation
- MCOs negotiate contracts with providers directly

Managed Care Benefits

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- Managed care leverages more primary care (currently, 24% of managed care costs are primary care while 11% for FFS).
- Physicians serving Medicaid enrollees can be reimbursed at rates higher than the State's traditional fee for service plans.
- MCOs' offer incentives to members for accessing care in order to promote better health, physician relationships, diagnostic testing, and healthier lifestyles.
- MCOs prior authorize less services than traditional Medicaid but do a better job at prior authorization.
- Most managed care savings come from coordinating care more efficiently to ensure services are not duplicated and that members are more compliant.

MCO Add-on Benefits (no cost to state)

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- **24-Hour Nurse Lines**
- **Extra vision services such as eye glasses**
- **Payment for healthy activities**
- **Weight management services like Weight Watchers**
- **Health and wellness rewards and incentives**
- **Dental incentives**
- **One on One education for asthma**
- **Text4Baby for new mothers**
- **Tools to assistance with healthy diets**
- **Many more***

Source: https://www.mountainhealthtrust.com/compare-plans

Medicaid Privatization Strategies

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- Transitioning Medicaid to private insurer model by transferring risk to private sector entities and implementing commercial market practices
  - In FY14, placed dental into managed care
  - In FY14, placed pharmacy into managed care
  - In FY15, implemented copays
  - In FY15, privatized NEMT with capitation
  - In FY15, placed quality withhold of 5% on MCOs
  - In FY16, implemented MLR at 85% for MCOs
  - In FY16, placed behavioral health into managed care
  - In FY16, placed expansion into managed care
  - In FY16, significantly reduced managed care rates

SFY17 Budget Reduction Proposals

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- Maximize CHIP match and traditional state matching funds
- Continue exploration of additional Medicaid privatization strategies
- Requested from CMS to eliminate NEMT for expansion
- Requested from CMS to increase copay for tobacco use
- Requested from CMS expansion population work requirement
- Assess benefits and align with states & commercial market
- Assess hospital enhanced payments
- Increase fraud, waste, and abuse efforts

Managed Care Reform- 2015

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Prior to 2015 contract (July 2014-June 2015), Medicaid managed care was not properly administered. DHHR has since built in several more strenuous accountability measures.

- Performance Withhold- 5% capitation withhold of approximately $27M
  - MCOs may "earn-back" their at risk capitation by meeting quality benchmarks set by BMS
  - Allows BMS to strongly steer quality improvement activities
  - Withhold is estimated to represent approximately $26.6 million
  - Measures focus on children, pregnant women, obesity, tobacco, behavioral health
- Liquidated Damages - Language added to outline a number of operational performance metrics corresponding to liquidated damages as a remedy
- Performance Profiling- Language added to allow BMS to publish information about MCO performance in a "report card."
- Timely Claims Payment- Language amended to clarify that the timely payment requirement applies to in-network and out of network providers. Language added to require interest payment for late claims (beyond 30 days).
- Corrective Action Plan (CAP)- Language added to allow for Corrective Action Plans to be imposed as a remedy for any non-performance under the contract.

Managed Care Reform- 2016

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- DHHR implemented a Medical Loss Ratio (MLR) cap in contract year 2016 to ensure appropriate management of profits in a manner similar to the commercial market.
- Additional penalties in contract for plans failing to comply with timeliness of payment
- Added behavioral health services
- Added Medicaid expansion population
- Added IBNR monitoring language
- Added one year plan lock in language
- Significantly reduced TANF rates

Managed Care Behavioral Health

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- Behavioral health spend continues to grow exponentially as WV statistics remain stagnant or worsen
- Public Works recommended that West Virginia integrate physical and behavioral health.
- Behavioral health and substance abuse treatment is integrated with physical health in private market insurance.
- Approximately 70% of adults with a behavioral health issue have a physical health issue as well.
- Cost of treating common diseases is exponentially higher when a patient has untreated behavioral health problems.
- Relative risk of premature mortality for people with severe mental illness is roughly 4x that of otherwise similar people.
- Behavioral health providers are in commercial payer networks.

Companies Providing Managed Care

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- Four companies currently participate in WV Medicaid
  - Unicare (WellPoint)
  - Coventry Cares of WV (Aetna)
  - The Health Plan of the Upper Ohio Valley
  - West Virginia Family Health (PSN partially owned by FQHCs)
- All plans have offices and staff located in West Virginia, some of which is required by the provider service agreement with BMS.
- Medicaid MCOs employ approximately 250 West Virginia employees across the state.

Managed Care Providers

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- Currently, one managed care company is operational in 55 counties (Coventry). Three managed care companies operate in 53 counties.
- Anticipated that all 4 MCOs will be in 55 counties before July 2016 (several waiver amendments pending).
- Pursuant to network adequacy standards, Medicaid MCO's manage a comprehensive and fully credentialed network, which is comprised of quality physicians, hospitals, pharmacies, dentists, and other health care providers.
- Medicaid managed care networks are required to offer at least as many providers as are available to Medicaid members in FFS.
- All four MCOs' offer provider networks that are more comprehensive than those available in FFS.

Managed Care Enrollment Before Expansion

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- In June 2015, there were approximately 210,000 individuals in managed care:
  - Children: 168,000
  - Pregnant: 4,500
  - Parent/Caretaker: 32,000
  - Transitional Medicaid: 5,500

Managed Care Enrollment After Expansion

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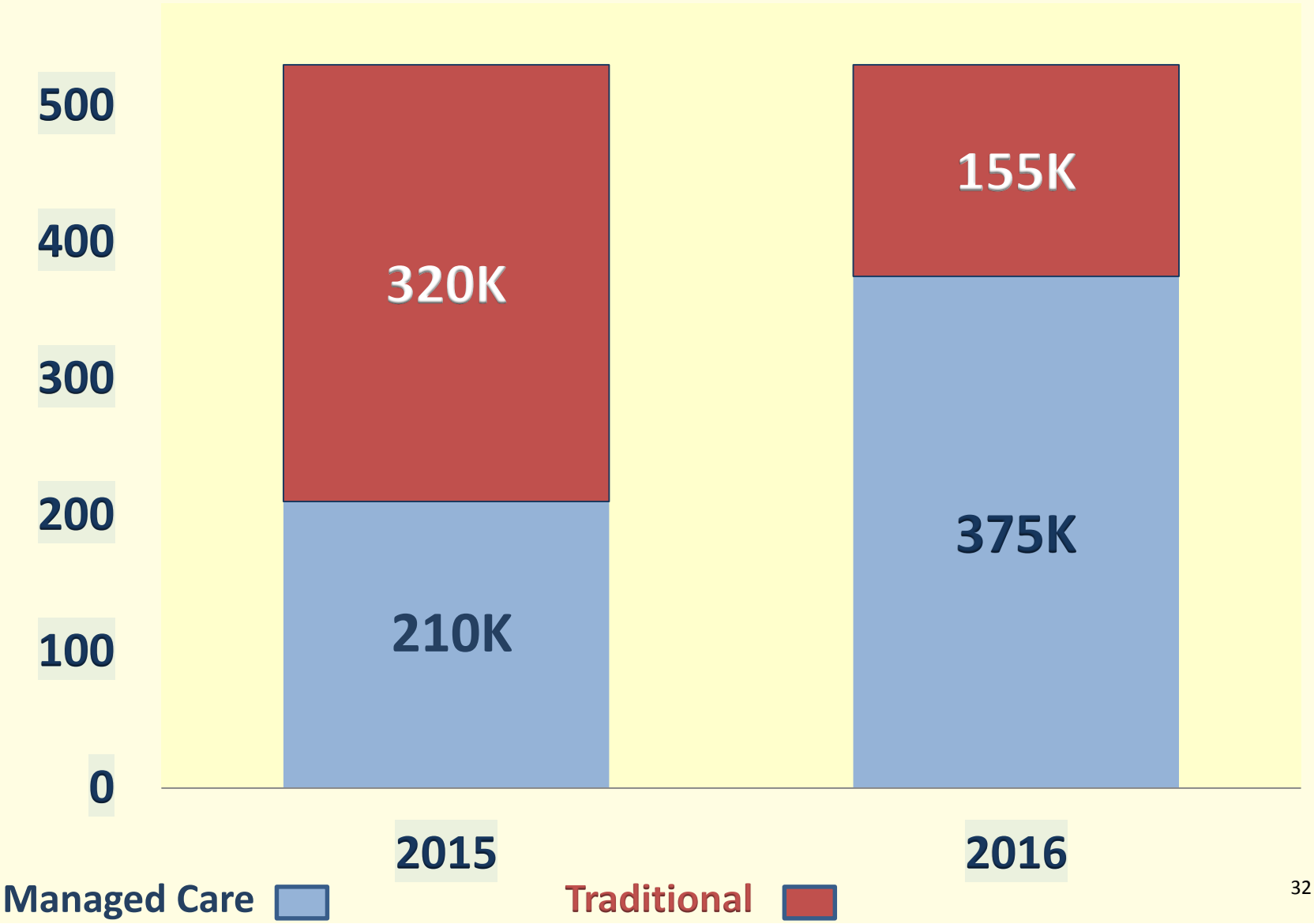
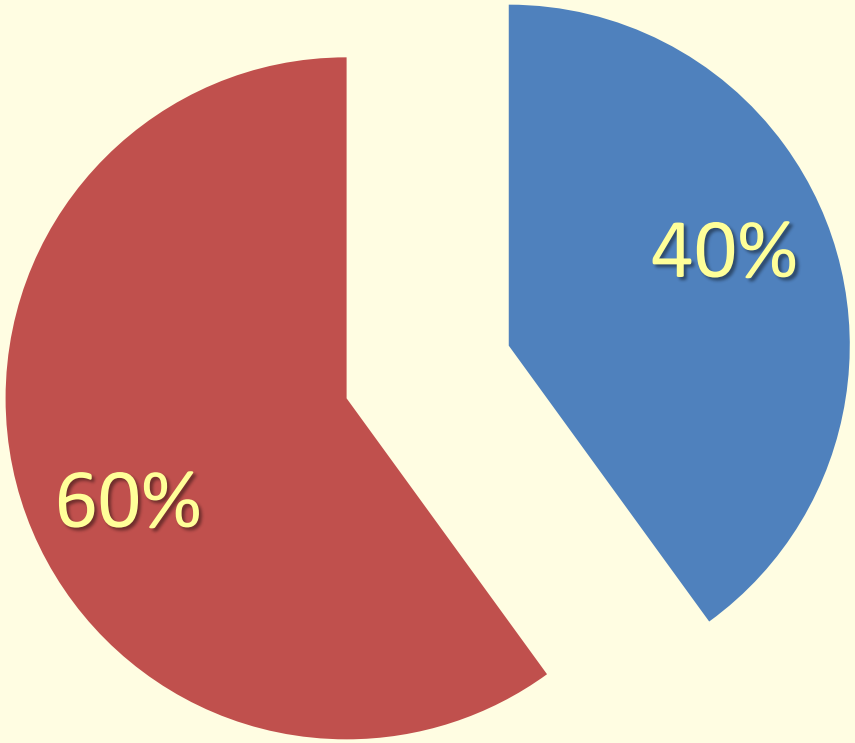
- Approximately 375,000, or over 70% of West Virginia Medicaid enrollees, is now in managed care.
- Nationally, nearly 80% of Medicaid enrollees receive services through managed care delivery systems.

Managed Care Enrollment (SFY)

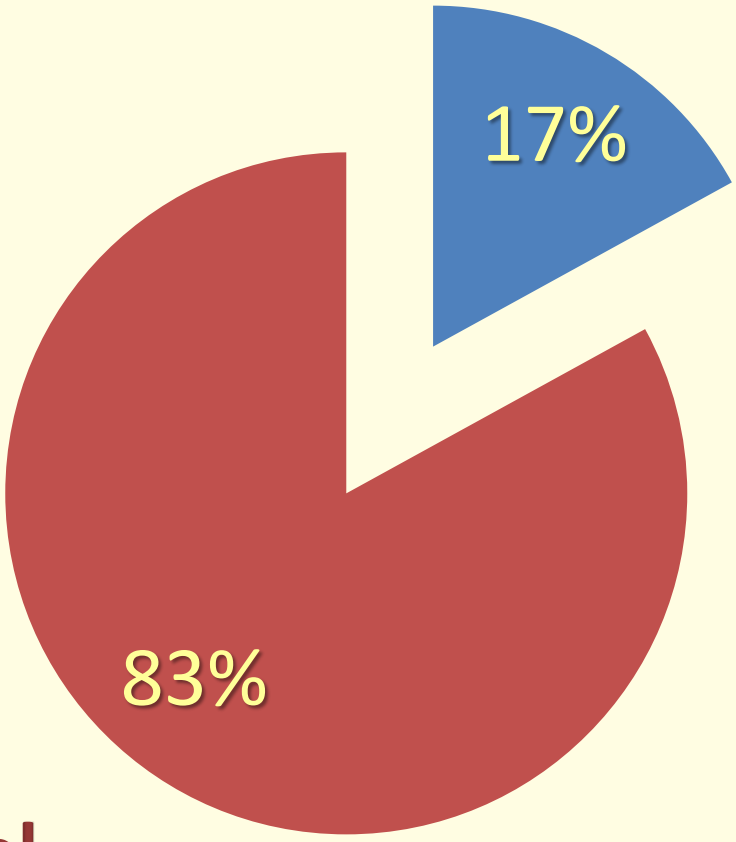


2015 Enrollment



Data Source – BMS **WVMEM105 Medicaid Membership Count**

2015 Medical Expenditures

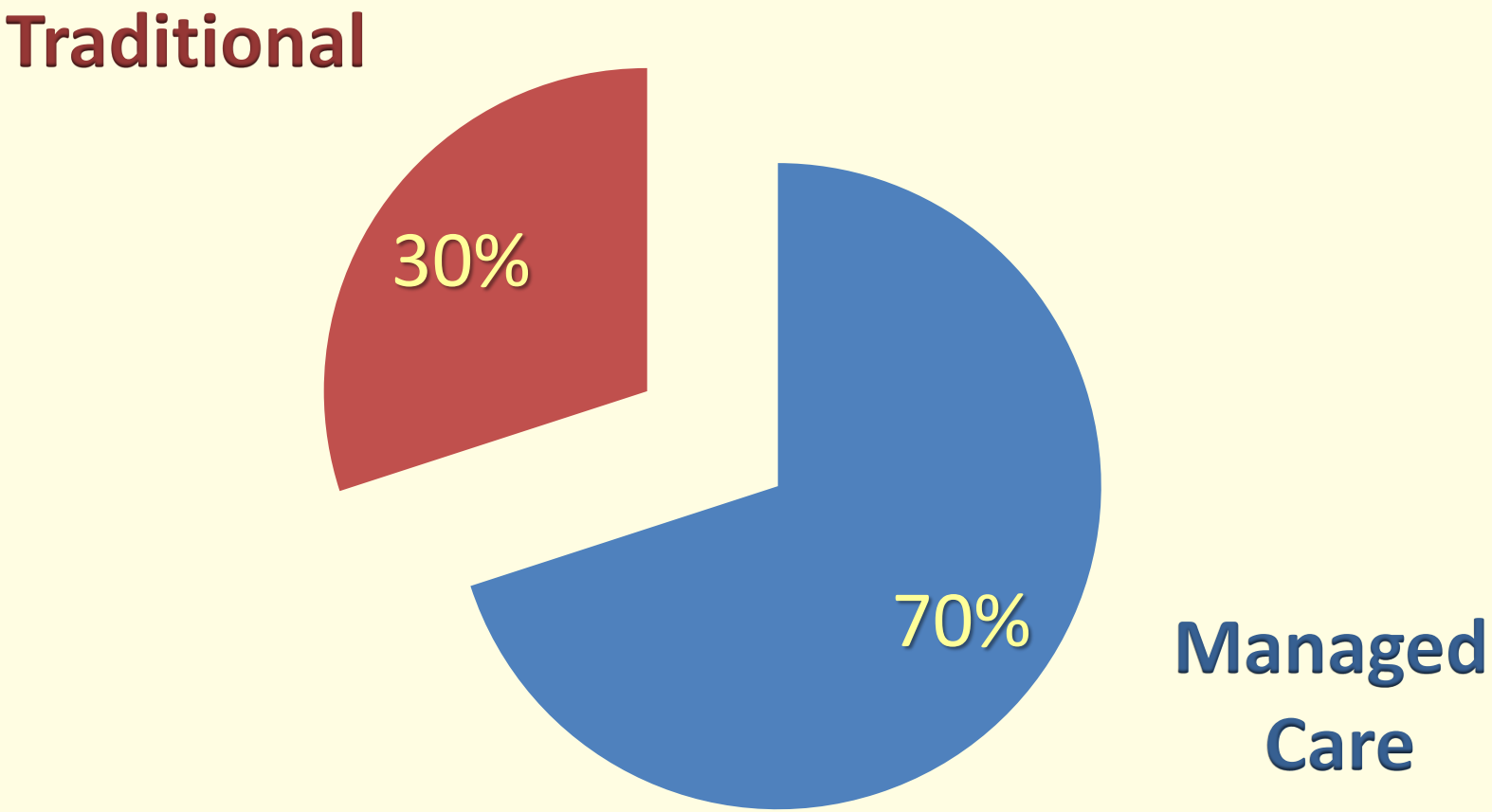


Managed Care

Traditional

Data Source – BMS LOCCHRA Reports

2016 Enrollment



Data Source – BMS/ Molina- Member Enrollment by Payer Type Summary SS for FY15

2016 Medical Expenditure

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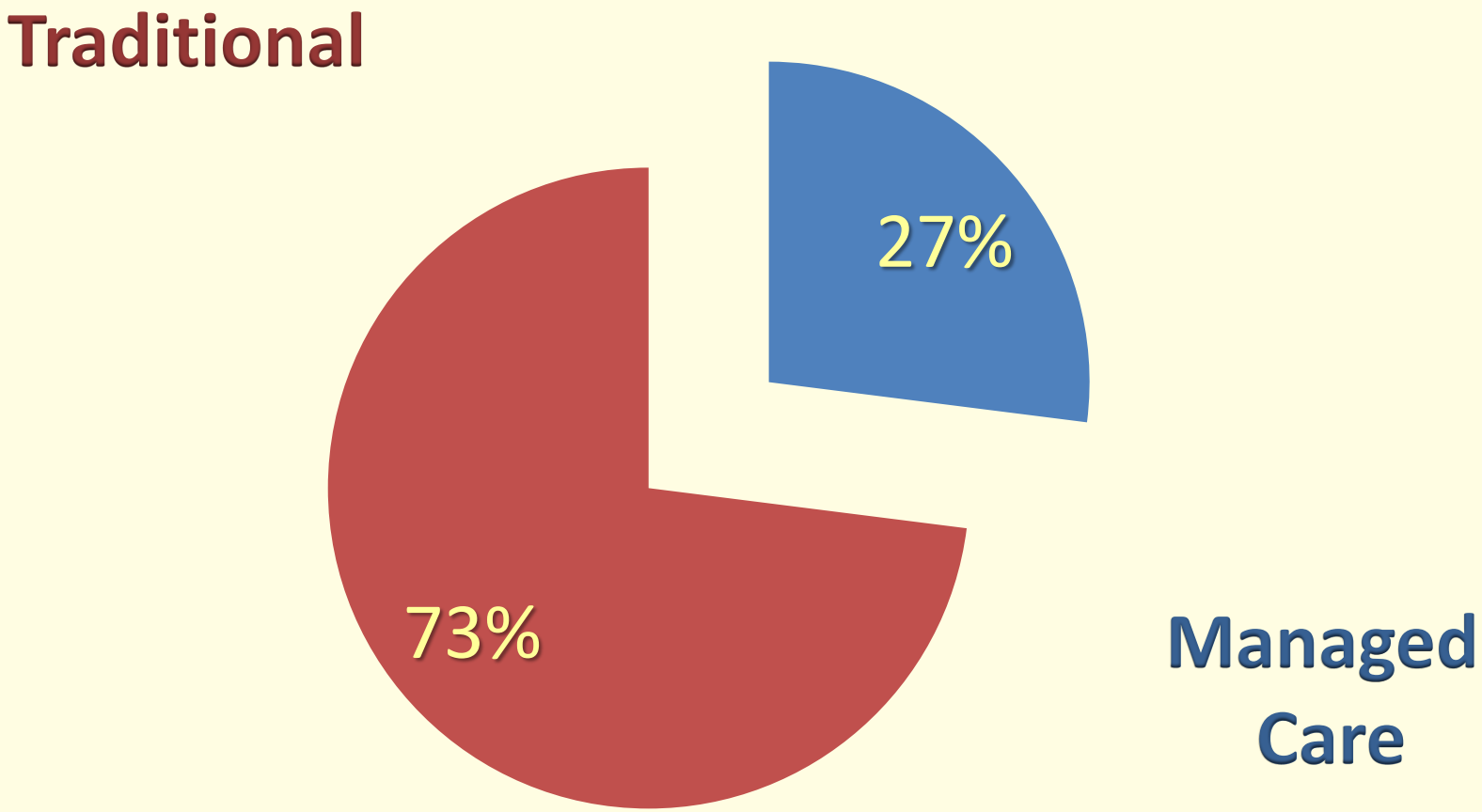

Data Source – BMS/ Molina- Member Enrollment by Payer Type Summary SS for FY15

Medicaid Expenditures on Managed Care

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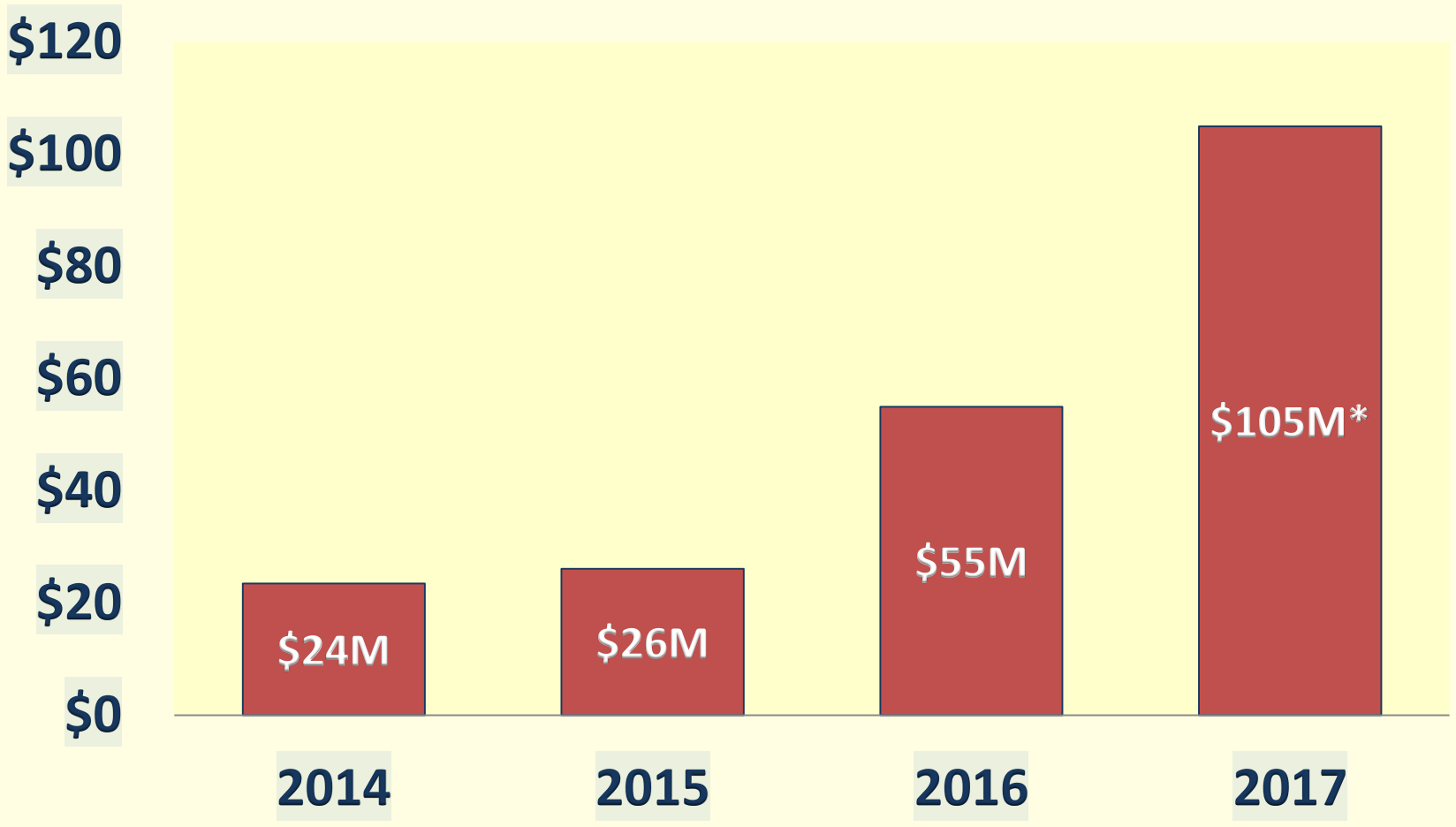
- Managed care expenditures in SFY15 were $615M
- Managed care expenditures are projected to be $1.06B in SFY16

Managed Care Total Savings



Source: Lewin Actuaries
Note: 2017 projection includes SSI

Managed Care Medical Loss Ratio

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- Medical Loss Ratio (MLR) is the share of premium revenues that a MCO spends on patient care and quality improve activities, as opposed to administration and profits.
- In contract year 2015, BMS adopted the Medicare MLR methodology used by CMS to oversee Medicare Health Maintenance Organizations.
- Under this formula, the numerator includes insurers' claims and expenses for activities that improve health care quality (patient education and counseling, care coordination, wellness assessments, etc.) the denominator subtracts from insurers' premium all federal taxes and state taxes and licensing or regulatory fees.

MLR Level Setting

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- The MLR has nothing to do with whether the state saved tax dollars through managed care
  - State savings are achieved, regardless of the MLR
  - The state sets the capitation lower than what fee for service would have cost
- If MLRs are too high it could result in insolvency, collapse of market, and providers not being paid
- A low MLR will reflect itself in lower rates the following year (example is dramatic 2015 to 2016 TANF rate reduction)
- Milliman Report for managed care is often misunderstood.
  - Report states that it should not be used for policy analysis due to formulaic impediments
  - Data is not audited and incomplete

MCO Medical Loss Ratios

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- 2014 MLR for each company:
  - Coventry – 77%
  - Unicare – 79.1%
  - THP – 77.6%
  - WVFH – joined the program in Q3 2014 so a full year MLR cannot be calculated
- In 2 of the past 3 years, average MLRs were at or above 85%:
  - 2011 – 85.6%
  - 2012 – 85.1%
  - 2013 – 82%

Source: Lewin Actuaries

Why have WV MLRs been low?

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- In 2014 and expected for 2015, WV Medicaid MCOs experienced lower MLRs for the following reasons:
  - ACA related enrollment freeze extended enrollment in CY2014
  - Improved care coordination strategies
  - Rx and Dental services were added with higher than expected savings
  - Medical inflation lower than initially projected
- **Despite mitigating factors, DHHR viewed these low MLRs as an opportunity for even greater state savings via lowered rates and MLR cap**

Resolution to MLR Issue

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- For CY15, DHHR implemented a change in the definition of MLR that better aligns the program with the Medicare approach.
- For CY16, the DHHR has employed a MLR penalty provision that requires MCOs to remit capitation if the annual MLR is below 85%.
- Commercial MLR is set at 85%.
- WV is now one of only states with MLR rebate.
- CMS proposed rules are expected to follow this approach in the future.

Managed Care and Quality

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- DHHR has greatly enhanced monitoring of quality in past two contracts.
- WV MCOs are required to maintain accreditation by the National Committee for Quality Assurance (NCQA), one of the nation's most respected standards of quality and effectiveness.
- DHHR is driving quality enhancement activities through its 5% quality withhold. To earn back the full 5%, MCOs must perform substantially better than the national average on an evolving series of HEDIS measures.
- DHHR is one of only states with a quality withhold and has one of the most aggressive quality withholds in country.

DHHR MCO Plan Quality Oversight 1

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Monitoring Activity	Description
MCO Quality Assessment and Performance Improvement Program	• MCOs must have an internal quality assessment and performance improvement program, which must include an approach for addressing systemic problems. • BMS' external quality review organization (EQRO) audits the program annually.
MHT Quarterly Reports	• MCOs must submit quarterly reports to BMS: – MHT-1: Enrollment and Membership Report – MHT-2: PCP Panel Report – MHT-3: Control totals for Monthly Encounter Data Electronic Submission – MHT-4: Experience Summary – MHT-5: Grievance Report – MHT-6: Lag Tables – MHT-7: Summary of Claims Paid Outside Encounter Data and Sub-Capitation Arrangements – MHT-7a: Experience Summary for Capitated Arrangements – MHT-9: Third Party Liability Collections – MHT-10: Grievance Report for Children with Special Health Care Needs – MHT-11: Member and Provider Services Functions – MHT-12: Mountain Health Choices – MHT-13: EPSDT Reporting – MHT-14: Medicaid-Related Financial Reports • BMS' actuarial/administrative contractor uses the reports to produce the MHT Dashboard for BMS, which compares MCO performance across time and across MCOs. The contractor follows up on issues identified through the reports and monitors their resolution on an ongoing basis.

DHHR MCO Plan Quality Oversight 2

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Monitoring Activity	Description
MHT Monthly Reports	• MCOs submit monthly reports to BMS on program integrity issues, which BMS reviews and forwards to the fiscal agent or other offices within BMS for appropriate action or follow up: – Third Party Liability Cases Not Pursued – Fraud and Abuse Reporting – Providers Denied Credentialing/Suspended/ Terminated
Annual Network Review	• BMS' actuarial/administrative contractor reviews each MCO's provider network against BMS' network standards. If any potential issues are identified through the review, the MCO must provide evidence that its network has the capacity to provide adequate access to members or agree to provide the services out-of-network.
Review of MCO Encounter Data	• **MCOs must submit encounter data on a monthly basis, which BMS' actuarial/administrative contractor validates and reviews for reasonableness.** • **Recently, BMS revised the mandatory encounter data submissions to further enhance the monitoring capabilities of BMS as well as support the requirements of the DHHR data warehouse.**

DHHR MCO Plan Quality Oversight 3

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Monitoring Activity	Description
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	• **Annually, each MCO performs a member satisfaction survey.** • **MCOs use the results to develop an action plan for areas identified as in need of improvement and provide quarterly updates to BMS on implementation of the action plan.**
Accreditation	• BMS requires that each MCO become accredited by the National Committee for Quality Assurance (NCQA)
External Quality Review	• The EQRO's audit includes three major activities, listed below (performance measure validation, PIP validation, and annual compliance review) • They produce a detailed Annual Technical Report that describes the review methods and conclusions regarding the quality, timeliness, and access to the care provided by the MCOs.
• **Performance Improvement Projects (PIPs)**	• MCOs must conduct at least two PIPs each year, which involve targeted interventions in a specific area to improve clinical or administrative processes. • MCOs conduct barrier analyses to identify effective interventions and must demonstrate sustained improvement over time. • The EQRO ensures the PIPs are conducted using a valid methodology and monitors the MCOs' intervention strategies and progress.
• **Annual Compliance Review**	• The EQRO assesses MCO compliance with structural and operational standards in the MCO contract. • MCOs must create internal corrective action plans if the MCO does not meet the passing threshold in the annual contract compliance review.

Quality Rankings

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- Quality rankings impacted by poor population health.
- In 2013, out of roughly 250 Medicaid MCOs in operation, WV's MCOs ranked 81st on average in the NCQA rankings; thereby placing them in the top third of all Medicaid MCOs.
- For 2013, THP moved into the top third of ranked plans in the NCQA rankings.
- For 2014, Coventry improved 21 spots in the NCQA rankings.
- Despite this, DHHR is not satisfied with where state MCO quality ranks and is actively seeking improvement via one of strongest quality withhold policies in nation.

Source: Lewin Actuaries

Quality Withhold

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- Despite poor population health, WV cannot lower the bar for quality for our children and vulnerable populations.
- In 2015 contract, all measures identified focused on children and pregnant women with 5 measures.
- In 2015, total withhold equates to approximately $27-30 million.
- DHHR reevaluates measures each year in conjunction with broad number of stakeholders.
- In 2016, three measures were added to address obesity, tobacco and medication adherence.
- It is envisioned that the contract will ultimately contain 10 measures, measures being changed as improvements achieved.

Quality Performance Measures

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1. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
2. Adolescent Well-Care Visits
3. Immunizations for Adolescents - Combination 1
4. Medication Management for People With Asthma (75% Compliance) – Ages 5 to 64
5. Prenatal and Postpartum Care – Postpartum Care
6. Annual Monitoring for Patients on Persistent Medications - Total
7. Adult BMI Assessment
8. Medical Assistance With Smoking and Tobacco Use Cessation (MSC) – Advising Smokers to Quit

Ensuring Consumer Access to Care

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- MCOs are required to assign members to a primary care physician- *area where we need to improve coordination.*
- MCOs must maintain networks at least as robust as those in the FFS. The Department regularly monitors and assesses network adequacy.
- The program operates under Federal authority that requires enrollees to have a choice of managed care organization. Members may choose MCOs as needed so as to take advantage of the provider network that best meets their needs.
- DHHR monitors and assesses formal appeals and grievances, Fair Hearing Requests, and informal provider and enrollee complaints related to access to care and addresses them on a case-by-case basis.

Consumer Appeal Rights

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- The MCO's grievance and appeals procedures must be understandable and accessible to Medicaid enrollees and must comply with federal requirements and West Virginia Statutes 33-25A-12, and must be approved in writing by the Department (42 CFR 434.32).
- Medicaid enrollees may file a grievance regarding any aspect of service delivery provided or paid for by the MCO. The enrollee may file an appeal to seek a review of an adverse action taken by the MCO as defined in 42 CFR 438.400(b).
- The MCO must submit to the Department a quarterly report summarizing each grievance and appeal handled during the quarter and a quarterly report summarizing all grievances.
- The MCO must resolve at least 98% of member appeals within 45 calendar days from the date the appeal is filed with the MCO, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee.

Plan Accountability 1

WEST VIRGINIA Department of Health & Human Resources

- DHHR has built into the managed care contracts several provisions where the plans may be penalized for failure to properly manage the Medicaid population.
- DHHR and Medicaid staff have been directed to investigate and hold accountable plans to the fullest extent of our regulatory capacity should any negligence or wrongdoing be found.
- The MCOs have also been notified of this approach.
- DHHR must have details in order to act.

Plan Accountability 2

WEST VIRGINIA Department of Health & Human Resources

#	Program Non-Performance	Measurement Period	Liquidated Damages
1	Failure to submit required reports, documentation, ad hoc reports, data certification forms, or any other data required within the timeframes provided by this contract or by the Department. The MCO may have a one business day grace period following the due date of the data, report, or form. Article II, 4.12, unless otherwise specified in this Exhibit.	Ongoing	$250 per day per each item that is overdue until the satisfactory submission of the required report, documentation, ad hoc report, data certification form, or data required to meet any State or federal reporting requirements After three (3) instances of non-performance during the contract period, the amount is increased by $1,000 per day per each item that is overdue.
2	Failure to comply with encounter data submission requirements including the failure to address or resolve problems with encounter records in a timely manner as required by Article III, 5.11.	Monthly	$1,000 per single encounter file per reporting period.
3	Failure to resolve at least 98% of member appeals within 45 calendar days from the date the appeal is filed with the MCO, unless an enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. Article III, 3.8.	Quarterly	$1,000 for each percentage point below 98% if the MCO fails to meet the standard.
4	Failure to respond to the State drug rebate disputes within 60 days as described in Article III, 9.13.	Ongoing	$35 per single NDC drug code submitted in each claim.
5	Failure to notify affected members of program or service site changes, at least fourteen calendar days before the intended effective date of the change. Article III, 3.4.	Ongoing	$250 per each incident per affected member.
6	Failure to report timely to BMS significant network changes as described in Article III, 2.1, Network Changes.	Ongoing	$500 per incident of non-compliance.

Plan Accountability 3

WEST VIRGINIA Department of Health & Human Resources

#	Program Non-Performance	Measurement Period	Liquidated Damages
7	Failure to meet provider credentialing requirements, including background screening requirements, specified in Article III, 2.1, Provider Qualification and Selection.	Ongoing	$500 per incident of non-compliance.
8	Failure to comply with the marketing requirements, or engagement in prohibited marketing practices. Article III, 3.1 and Exhibit D.	Ongoing	$1,000 per each incident of non-compliance.
9	Failure to pay 7% annual interest on the same date as an in-network clean claim that remained unpaid beyond the 30-day claims payment deadline. Article III, 2.7, Timely Payment Requirement.	Quarterly	$500 per each in-network clean claim for which the interest remained unpaid on the same date as a claim's payment.
10	Failure to provide timely MCO covered service as described in the Exhibit A of this Contract when, in the determination of BMS, such failure results in actual harm to a member or places a member at risk of imminent harm.	Ongoing	$7,500 per day for each incident of non-compliance.
11	Failure to provide timely service authorization (prior authorization) as described in Article III, Section 5.4 or a failure to honor service authorization as described in Article III, Section 5.4, Continuity of Care.	Ongoing	$5,000 per incident of noncompliance.
12	Failure to reimburse a pharmacy for providing a 72-hour emergency supply as outlined in Article III, 9.6 or failure to make a prior authorization determination within 24 hours of the request without providing sufficient amount of the emergency medication supply as outlined in Article III, Section 9.3.	Ongoing	$5,000 per incident of noncompliance.

Summary of Managed Care Savings

WEST VIRGINIA Department of Health & Human Resources

- Savings from managed care were $23.5M in SFY2014 and $26.1M in SFY2015.
- Dramatic Managed Care TANF Rate Reduction in SFY16
  - SFY15 pmpm was $241 and SFY16 pmpm is $223
- Projected savings from existing populations with addition of expansion and behavioral health into managed care for SFY16 is $55 million total
- Cost mitigation from SFY2016 through SFY2020 due to moving expansion and behavioral health into managed care with TANF is over $290M in state and federal dollars.
- Transitioning SSI projected to mitigate costs approximately $50 million annually in additional cost mitigation if implemented

Source: Lewin Actuaries

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