Managed Care Quality Strategy

2nd Edition

2011 - 2015

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Richmond, Virginia 23219

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FORWARD

Medicaid's Medallion II program was created for the purpose of improving access to care, promoting disease prevention, and ensuring quality care through contracted managed care organizations (MCOs). The launch of Medallion II occurred in the mid-'90s in the midst of rapid and, often, controversial changes to State and Federal policies that directly impacted on the perceptions of lawmakers, providers, and Medicaid recipients – regarding managed care.

After testing, spreading, and then refining the use of other delivery systems for Virginia Medicaid, Medallion II began in 1996 in seven Tidewater locations, and expanded just a year later to an additional six adjacent cities and counties. Medallion II managed care expansions continued and, as of January 2011, the program was operational in 115 localities with 535,639 enrolled recipients - 63 % of the Medicaid population. The remaining 37% were served through fee-for-service or primary care case management (PCCM).

In 2002, Virginia's children's health insurance program (CHIP) began and the majority of enrollees were, and continue to be, served through the managed care delivery system. As of January 2011, there were 51,145 CHIP enrollees in managed care (86% of the CHIP population).

Virginia has focused on quality while expanding managed care. In fact, Virginia was one of the first states to require its Medicaid and CHIP MCOs to be accredited by the National Committee for Quality Assurance (NCQA) – a mutually beneficial achievement for the MCOs, enrollees, and the Department of Medical Assistance Services (DMAS). NCQA accreditation is recognized among industry leaders, consumers, government leaders, purchasers, and providers as a representation of and a commitment by the MCOs toward continuous quality improvement of health care processes and outcomes. NCQA's methods and standards for MCOs to attain *and* maintain accreditation are rigorous, ongoing, and performance-based. The requirement for NCQA accreditation is one of Virginia's key strategies for providing a high quality managed care system for eligible Virginians.

States with Medicaid managed care, such as Virginia, are required by the Code of Federal Regulations (CFR) 42 438.202(a) to have a written quality strategy. The first edition of DMAS' quality strategy was published in June 2005. In December 2009, the Centers for Medicare & Medicaid Services (CMS) added the requirement for states to also include CHIP and, as such, this Managed Care Quality Strategy was formulated as DMAS' second edition Quality Strategy. It was developed in partnership with the MCOs, with opportunity for public comment, and review and approval from CMS.

This edition includes the value-added benefits from NCQA accreditation standards and from regulatory requirements that enable DMAS and its contracted MCOs to provide a system of high quality managed care. The NCQA's Healthcare Effectiveness Data and Information Set (HEDIS), a robust set of quality measures, is a key component of DMAS' means of monitoring the value of its managed care delivery system.

This strategy is designed to serve as a framework for the next five years. It can be used as a source document for DMAS, MCOs, and other key stakeholders with a shared interest in improving the health of the people we serve. If there are significant State and/or Federal policy or regulatory changes that would warrant a revision to the strategy before the five-year period ends, DMAS may

revise and publish a new edition of the strategy, with opportunity for public comment and CMS' approval. DMAS welcomes *your* feedback on the strategy so that future editions are even better.

I. Introduction and Goals

The Department of Medical Assistance Services (DMAS) administers health care services to Virginians who qualify for either the Medicaid program or the Children's Health Insurance Program (CHIP). The Medicaid and CHIP programs are financed by Federal and State funds, administered by the State according to Federal and State guidelines, and are monitored closely by DMAS staff and the Centers for Medicare & Medicaid Services (CMS). Both programs in Virginia are administered through two delivery systems: fee-for-service (FFS) and managed care. Consistent with the Code of Federal Regulations (CFR) and CMS requirements, this edition of the Quality Strategy is focused entirely on the managed care delivery system.

Within Medicaid managed care, DMAS operates two distinct managed care programs: 1) MEDALLION, a primary care case management (PCCM) program administered by DMAS; and, 2) Medallion II, a program administered through contracted managed care organizations (MCOs). The managed care programs are administered in accordance with a CMS 1915(b) Managed Care Waiver, Federal and State Regulations. Consistent with CMS requirements, this Managed Care Quality Strategy includes the Medallion II program only (not MEDALLION).

The managed care delivery system for CHIP has one distinct program: Family Access to Medical Insurance Security Plan (FAMIS), which is administered through contracted MCOs. It is also included in this edition of the quality strategy.

Table 1 delineates the categories of eligible Virginians who receive their Medicaid or CHIP services through the FFS or MCO delivery systems.

Table 1

Fee-for-Service	
Program Name	**Description**
*Medicaid Fee-for-Service	Standard Medicaid Program under Title XIX.
*FAMIS (Family Access to Medical Insurance Security Plan)	Title XXI Children's Health Insurance Program (CHIP) and the CHIP Medicaid Expansion Program.
Managed Care	
Medallion II	Title XIX Medicaid program that utilizes contracted managed care organizations (MCOs).
*PCCM	Title XIX Medicaid Managed Care Program utilizing contracted primary care case management (PCCM) providers in certain localities.
FAMIS MCO	Title XXI Children's Health Insurance Program (CHIP) and the CHIP Medicaid Expansion Program utilizing contracted MCOs.

***** Programs not included in the Quality Strategy.

A. Quality Strategy Development

States with Medicaid managed care, such as Virginia, are required by Federal Regulations, specifically the Code of Federal Regulations (CFR) 42 438.202(a), to have a written quality strategy. The first edition of DMAS' quality strategy was published in June 2005. In December 2009, CMS added the requirement for states to also include CHIP and, as such, this Managed Care Quality Strategy was formulated as DMAS'second edition. This edition is designed to serve as a blueprint for continuous quality improvement of health care services provided through the Medicaid & CHIP managed care delivery system.

1. Development Plan

The Quality Strategy was developed by DMAS' Division of Health Care Services, through a multi-faceted approach which began with senior leadership's approval of a "project charter." These milestones were reached to develop the strategy:

- Gathered and reviewed other state's quality strategies to identify best practices and generate ideas;
- Conducted cross-walk between DMAS' first Quality Strategy and the required elements delineated by CMS in order to identify gaps and opportunities for improvement;
- Gathered internal (DMAS, MCO contracts) and external (CMS, CFR, NCQA) documents to guide the content of the strategy;
- Developed first draft of strategy;
- Collected and reviewed feedback from DMAS subject matter experts;
- Developed second draft;
- Collected and reviewed feedback from DMAS managers and Medicaid/CHIP MCO managers and quality improvement staff to ensure intent and content of the strategy would be useful to key stakeholders;
- Developed third draft;
- Collected and reviewed feedback from DMAS senior level leaders with approval to post the strategy for public comment;
- Posted final draft for public comment on the internet;
- Reviewed and considered comments received from the public to ascertain necessity for edits;
- Reviewed and approved by DMAS senior level leaders;
- Reviewed and approved by CMS; and,
- Posted in public domain with invitation for comments.

2. Beneficiary and stakeholder input

Internal and external key stakeholders were invited to review the strategy before it was considered "final." Internal stakeholders included representatives from Health Care Services and other DMAS divisions, including: Maternal and Child Health; Behavioral Health; and, Policy and Research.

DMAS sought public comments through the established web-based system that is used exclusively by state agencies for soliciting public comments. The area for soliciting comments is located within the Commonwealth of Virginia's Town Hall website.

The final draft was posted on the "Town Hall" website, and written feedback was due by 03/25/11. A screen shot of the announcement can be found in Appendix A. Comments were submitted separately by the Virginia Association of Community Services Boards, Inc. and the Virginia Association of Centers for Independent Living. All comments were reviewed, assessed, and considered for integration into the strategy.

The comments were valuable with regards to the ongoing planning of how care is delivered, however, the scope of the comments is not applicable to the *current* structure of managed care quality. The comment letters are in Appendix B and C along with the Department's prepared response to each.

CMS reviewed the strategy and provided suggestions, which included adding: quantifiable goals for the State; additional language on the use of intermediate sanctions; and, further clarification on the State's NCQA deeming for compliance review.

DMAS revised the strategy based on CMS' feedback, and posted it a second time on the "Town Hall" website for public comment. Written feedback was due by 06/21/2011. No comments were received.

Approval from CMS was the final step before publication. The approval letter received on 05/19/11, can be found as the back page of the Appendix.

B. Managed Care Quality Vision and Mission

DMAS' managed care quality vision and mission statements are designed to support the agency's mission and the goal of managed care. It's through the alignment of these visionary statements that DMAS is able to strategically practice continuous quality improvement on the structure, process, and outcomes of the managed care programs.

DMAS Mission:

To provide a system of high quality and cost effective health care services to qualifying Virginians and their families.

DMAS Managed Care Goal:

To provide a cost-effective managed care delivery system for eligible Medicaid and CHIP enrollees that far exceeds the industry standards for timeliness, access, and quality care.

DMAS Managed Care Quality Vision:

Virginians who receive Medicaid or CHIP health care services through managed care will receive the right care, in the right way, at the right time, *EVERY TIME*.

DMAS Managed Care Quality Mission:

Virginia's Medicaid and CHIP Managed care delivery system is structured to enable enrollees to achieve and maintain optimal health. This is accomplished by: administering health care benefits through accredited managed care organizations; complying with all relevant Federal and State statutes; and, continuously improving access, timeliness, and quality of care.

Reader Tip #1:

When a document name is followed by a 💻 symbol, the document can be found on the DMAS website http://dmasva.dmas.virginia.gov/ through a simple word search.

II. Review of Quality Strategy

DMAS developed the 2nd edition Quality Strategy with the intention of having a strategy that is functional for five years. DMAS has a methodical approach to monitor the functionality of the current edition and to prepare for the next edition of the Quality Strategy.

A. Method and frequency of reviewing the strategy for effectiveness

The Quality Strategy will be reviewed for its effectiveness on an annual basis by the external quality review organization (EQRO). The findings will be included in the EQRO's annual technical report (ATR 💻) on the quality of DMAS' managed care delivery system. The ATR is required by CMS and must include an assessment of the state's quality strategy.

B. Indicators that warrant a change to the strategy

A significant change to the Quality Strategy is one that is likely to affect the delivery or measurement of the quality of health care services delivered through Medicaid/CHIP Managed Care delivery system. Federal and State health care reform is creating the need for rapid regulatory and policy changes, many of which may have significant impact on the delivery or measurement of health care received through managed care. Additionally, changes to NCQA standards, which are published annually, could also be considered significant. These changes are carefully monitored to ensure the Quality Strategy does not conflict with these public policies.

Changes to formatting, dates, or changes that do not impact on the intent or content of the Quality Strategy will be considered "insignificant."

If significant changes are made to this edition of the Quality Strategy, the revision(s) will include a public comment period, CMS review and approval, and a resultant new edition. Insignificant changes would not warrant the need for a new edition.

C. Timeframes for updating the Strategy

DMAS will publish a new edition of the Quality Strategy every five years. The Quality Strategy development plan used for this edition will be replicated in time for the new edition to be published by 2016.

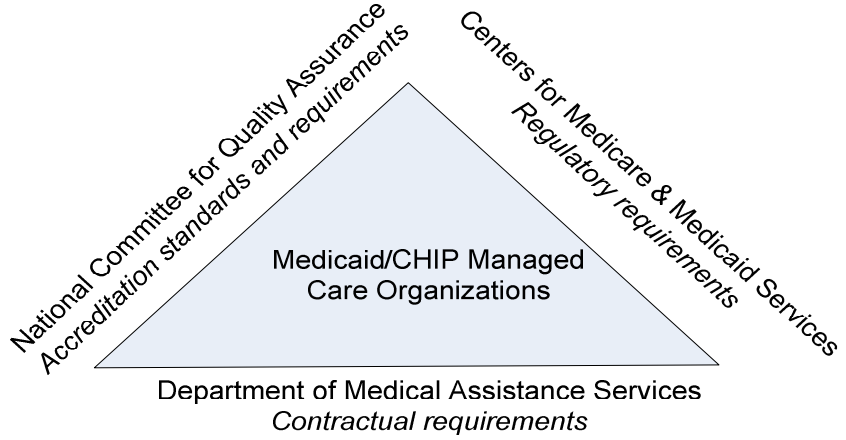
III. DMAS Approach to Managed Care Quality Assessment

Tactic: DMAS developed and uses a quality framework that leverages existing sets of standards and requirements for providing and continuously improving the quality of its managed care delivery system.

There are three fundamental sets of requirements and standards from CMS, DMAS, and NCQA that converge for a bold quality framework for Virginia's Medicaid/CHIP managed care delivery system. Some of the requirements and standards overlap, resulting in resource efficiencies for assessing quality; however, each set provides for a different and important perspective on the quality of managed care.

The requirements and standards serve as the basis for this edition of the Quality Strategy and are depicted in the framework in Diagram 1.

Diagram 1 Medicaid/CHIP Managed Care Quality Framework



The contracts between DMAS and each MCO provides for a legal order of precedence in the following order:

a. Federal Regulations
b. Virginia State Plan
c. Medicaid and CHIP Waivers
d. Medicaid and CHIP State Regulations
e. DMAS Medicaid and CHIP contracts with MCOs.
(It should be noted that the DMAS Medicaid and CHIP contracts with MCOs explicitly state that the MCO must be NCQA accredited).

Should there be any conflicting requirements or standards between CMS, DMAS, or NCQA, the legal order of precedence is followed. The following descriptions summarize the perspectives of each set of standards (not in order of precedence).

A. Federal Regulations via Centers for Medicare & Medicaid Services

CMS Medicaid managed care quality requirements are set forth throughout 42CFR Subpart D (Quality Assessment and Performance Improvement). Key Sections of the CFR, which are addressed throughout this strategy, include:

Section 438.202 State responsibilities
Section 438.204 Elements of State quality strategies
Section(s) 438.206 – 210 Access standards
Section(s) 438.214 – 230 Structure and operations standards
Section(s) 438.236 – 242 Measurement and improvement standards

Even further, 42CFR Subpart E (External Quality Review) sets forth requirements of States to provide for an external quality review of each MCO annually. The CFR requires states to ensure that the external quality review (EQR) is conducted by qualified external quality review organizations and follows detailed protocols set forth by CMS.

The provision of EQR activities is a core feature of Virginia's Medicaid Managed Care quality initiative. States with Medicaid managed care are required to provide for three mandated EQR activities as follows:

1) Validate a sample of each MCO's performance measures – annually;
2) Validate two or more performance improvement projects (PIPs) for each MCO – annually; and,
3) Provide comprehensive review of MCO compliance with Federal and State operational standards – once every three years.

These and other Medicaid Managed Care quality assessment activities are conducted for DMAS by an external quality review organization (EQRO). DMAS contracts with a quality improvement organization (QIO) to serve as the EQRO for Virginia. Consistent with CMS guidance, the EQRO conducts these mandated activities using CMS published protocols.

There is some overlap between NCQA's quality standards the MCOs must meet to maintain accreditation and the three (3) CMS-mandated quality activities. When these overlaps are clear, DMAS deems most of the duplicative CMS-EQR requirements as being met (hereafter referred to as "deeming") so long as the MCO meets the accreditation standards. The criteria for deeming is supported in 42CFR 438.360 (non-duplication of mandatory activities).

NCQA annually publishes an updated crosswalk between the CMS quality standards and NCQA accreditation standards. While CMS does not formally endorse the crosswalk, CMS participates in the review process before the crosswalk is published. Therefore, DMAS views the crosswalk as a guide, and not a determination of deeming in and of itself.

DMAS and the EQRO conduct an in-depth review of the cross-walk and use it as a guide for ascertaining which standards can be deemed as being met during the comprehensive onsite review. If there seems to be any ambiguity in the crosswalk or any standards that, in the opinion of the EQRO and DMAS, should not be deemed, the standards in question are included in the comprehensive review. The commonality between those elements deemed as "not met" and

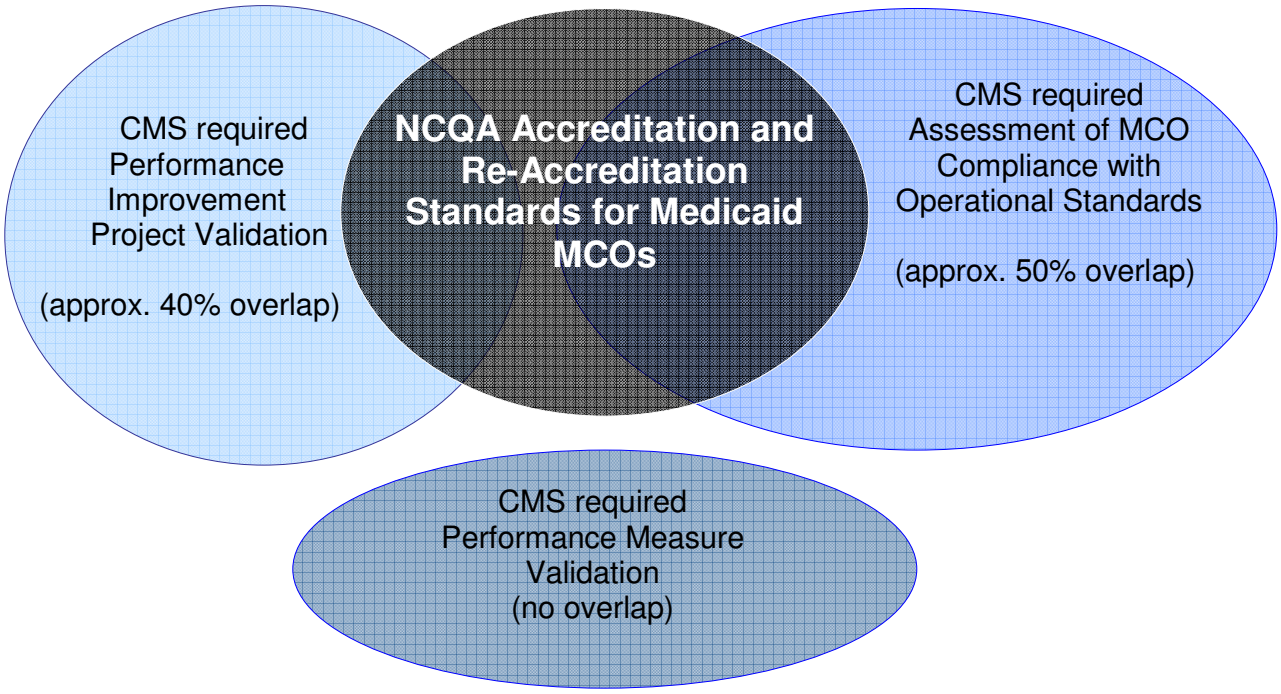
needing to be reviewed by the EQRO are those that the CFR requires (and NCQA does not); and those where the CFR enables states to define the policies and criteria.

The most recent comprehensive review was conducted in the first quarter of 2011. See Appendix E for the matrix used for declaring an element deemed as being met or not.

A similar process is used to identify duplicative elements within the PIPs validation. DMAS selects two HEDIS measures for the annual PIPs requirements. The matrix used for the 2010 PIPs validation can also be found in Appendix E.

See Diagram 2 for a snapshot of Federally required EQR activities and the extent of duplication for each with NCQA accreditation standards. Although the performance measure validation activity seems duplicative of annual HEDIS audits experienced by the MCOs, it may not be deemed, per CMS.

Diagram 2 CMS Mandated External Quality Review Activities Partially Overlap with NCQA Accreditation Standards



B. NCQA Accreditation

Virginia was one of the first states in the nation to require its Medicaid MCOs to be accredited by the NCQA – a mutually beneficial achievement for the MCOs, enrollee and DMAS. With approximately 65% of Virginia's Medicaid/CHIP population served by MCOs, the benefits of accreditation impact on more than half a million Virginians.

NCQA accreditation is recognized among industry leaders, consumers, government leaders, purchasers, and providers as a representation of and a commitment by the MCOs toward continuous quality improvement of health care processes, structure, and outcomes. NCQA's methods and standards for MCOs to attain *and* maintain accreditation are rigorous, ongoing, and performance-based.

NCQA accreditation enables the MCOs, DMAS and key stakeholders to use the NCQA's healthcare effectiveness data and information set (HEDIS) for measuring managed care performance. The score for each HEDIS measure is calculated by following very specific and methodical technical specifications set forth by NCQA. Each MCO calculates their scores for each measure, either by using administrative data or by using a combination of administrative data and medical record abstraction. The NCQA further requires each MCO to have their scores audited by a certified HEDIS auditor prior to acceptance by NCQA.

The HEDIS scores are collected, analyzed, synthesized, and published by NCQA each fall to enable MCOs and key stakeholders to identify opportunities for improvement, set benchmarks and goals, and measure progress from year-to-year. Additionally, the NCQA website allows for an automated "report card" to be generated as a snapshot of an MCO's performance. The report card takes into account the MCO's HEDIS scores, consumer satisfaction scores, and accreditation level. This level of transparency allows for informed decision making when consumers are given choices for an MCO.

C. Department of Medical Assistance Services

Throughout the CFR, there are sections that either begin with or include "the state must…" These statements within the CFR provide requirements for assuring the State and the MCOs are held accountable for having the structure, operations, and outcomes that are expected as a result of having an effective managed care delivery system.

Further, the business agreement between DMAS and each MCO is codified through written Contracts 💻 and is designed to ensure and report on compliance with the CFR. As of the publication of this edition of the Strategy, the contracts for Medicaid and CHIP were separate, though very similar. In fact, the quality improvement requirements set forth in the Medicaid and CHIP contracts are identical and have been for a number of years.

Reader Tip #2

Sections III and IV of the strategy delineate the quality requirements and standards from the CFR that States must be accountable for through assurances with Medicaid MCOs. Unless otherwise specified, DMAS has assumed that the CFR is also applicable to CHIP. A fixed table will be used intermittently and throughout this section of the strategy to demonstrate how DMAS is adhering to the CFR requirements for states.

1. CHIP Contract Provisions for Assessing Quality

Even though the CHIP managed care quality Federal regulations had not been issued at the time this edition of the strategy was published, preliminary information from CMS strongly suggests the regulations will mirror the Medicaid managed care quality regulations. Therefore, for purposes of having a meaningful structure in place for managed care quality, DMAS made the assumption that the impending CHIP managed care quality regulations will be the same as the Medicaid managed care quality regulations. When the CHIP regulations are published, DMAS will assess the need to revise this edition of the Strategy and publish a new one. Provisions in the CHIP MCO contracts replicate the Medicaid managed care established standards for access to care, structure and operations, and quality measurement and improvement.

2. State Standards for Access to Care

a) Availability of Services

DMAS has adopted standards that are at least as stringent as Federal Medicaid regulations for access to care and has delineated the following contractual requirements of the Medicaid/CHIP MCOs as evidenced in Table 1.

Table 1

Health Care Service Availability (42CFR 438.206) *
CFR requires the State to: ensure that all services covered by the State plan and delivered through contracted MCOs are available and accessible to enrollees by having an adequate provider network; providing access to covered services through providers who are within reasonable travel time; providing the full scope of Medicaid and CHIP services; having timely access to services; and, providing services in a culturally competent manner. **In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:** 1) Have an adequate provider network 438.206(b) o One (1) full-time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 enrollees o One (1) FTE PCP with pediatric training and/or experience for every 2,500 enrollees under the age of eighteen o Female enrollees of age thirteen or older have direct access to a participating obstetrician-gynecologist for annual examinations and routine health care services without prior authorization from the PCP; o Physicians and other health care professionals providing service are licensed by the State and have proper certification or training to perform medical and clinical services; 2) Provide access to covered services through providers who are within reasonable travel time from the enrollees residence 438.206(b) o Provider network has a minimum of at least two (2) PCPs for enrollees to choose from who are located within a maximum of thirty (30) minutes travel time from enrollees in

Health Care Service Availability (42CFR 438.206) *
urban areas and sixty (60) minutes travel time in rural areas; o Obstetrical services are available within a maximum of forty-five (45) minutes travel time from any pregnant enrollee; o Coverage for a second opinion when requested by the enrollee for diagnosing an illness and/or confirming a treatment plan; 3) Provide the full scope of Medicaid and CHIP services, with the exception of the carved-out services and other exclusions 438.206(b) o Provider network and referral listing includes an adequate number of specialists to provide covered services to enrollees; o All care that was pre-authorized and provided out of network shall be covered and paid for; 4) Provide for timely access to services 438.206(c) o Appointments for emergency services shall be made available immediately upon the enrollee's request; o Appointments for an urgent medical condition shall be made within twenty-four (24) hours of the enrollee's request; o Appointments for routine, primary care services shall be made within thirty (30) calendar days of the enrollee's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days, or for routine specialty services, such as dermatology, allergy care, etc. o Appointments for maternity care shall be provided for initial prenatal care appointments as follows: - First trimester - within fourteen (14) calendar days of request - Second trimester - within seven (7) calendar days of request - Third trimester - within three (3) business days of request o Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the MCO or maternity provider, or immediately if an emergency exists. o Emergency covered services are available twenty-four (24) hours a day, seven (7) days a week, either in the MCO's contracted facilities or through arrangements with other subcontractors. o Emergency sites that are as conveniently located as possible for after-hours emergency care shall be designated by the MCO. o 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/FAMIS Plus enrollees. 5) Provide services in a culturally competent manner 438.206(c) o Oral interpretation services are available from trained professionals to ensure effective communication with the enrollee, a family member, or friend regarding treatment, medical history, or health education; o A minimum of two (2) medically trained professionals in the network who can speak a

Health Care Service Availability (42CFR 438.206) *
common language with enrollees who are non-English speaking and when the common language is spoken by five hundred (500) or more of its enrollees; and, o TTY/TDD services provided for the hearing impaired.

*It is assumed that the impending Federal regulations for CHIP managed care will duplicate those for Medicaid managed care.

b) Adequacy of Services

DMAS requires the MCOs to assure adequate capacity and services for Medicaid and CHIP. To demonstrate this, the MCOs are required to:

1) Offer an appropriate range of preventive, primary care, and specialty services.
2) Maintain a network of providers that is sufficient in number, mix, and geographic distribution.

Table 2 outlines the assurances the MCOs are accountable to DMAS for in order to demonstrate there is adequate capacity and services for enrollees.

Table 2

Assurances of Adequate Capacity and Services (42CFR 438.207) *
CFR requires the State to: ensure that each MCO provides assurances to the State and provides documents to demonstrate that there is adequate capacity to serve the enrollment in the respective service area(s) and in a manner that meets State standards for access to care. **In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:** Have the capacity to serve the expected enrollment in its service area 438.207(a) o Monitor the provider network to ensure that the access standards set forth in the MCO contracts are met; o Have a utilization management plans to include utilization review, prior authorization, and case management; o Provide DMAS with: - files containing MCO provider network information to allow for assessment of the MCO's network capacity and availability of services; - sample network provider agreements (including attachments to the agreement that the provider must sign; - the policies and procedures the MCO uses for the credentialing process (which must match the credentialing and re-credentialing standards from NCQA); - the policies and procedures for notifying PCPs of panel composition; - the policies and procedures for member enrollment verification for in- and out-of-network providers; - the policies and procedures for ensuring access to needed services for enrollees with disabling conditions, chronic illnesses, or child(ren) with special health care needs (e.g., specialist to act as PCP).

Assurances of Adequate Capacity and Services (42CFR 438.207) *
Offer an appropriate range of preventive, primary care, and specialty services 438.207 (b) o Cover services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients, as set forth in 12 VAC 30-50-180. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician. Renal dialysis clinic visits are also covered; o Ensure access to specialty services for enrollees of all ages with disabling conditions and/or chronic illnesses; and Ensure access to specialty services for children with special health care needs.

*It is assumed that the impending Federal regulations for CHIP managed care will duplicate those for Medicaid managed care.

c) Coordination and continuity of care

Table 3 outlines the specific requirements the MCOs must meet in order for care to be well coordinated and seamless to enrollees. The parameters are designed to enable the primary care physician to be at the center of coordinating care among the various providers who can best meet the needs of the enrollees. It is through this level of coordinated care that enrollees can achieve optimal health.

Table 3

Coordination and Continuity of Care (42CFR 438.208) *
CFR requires the State to: ensure that each MCO provides primary care and coordination of health services for all MCO enrollees and, even further, includes the service coordination for enrollees with special health care needs. **In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:** 1) Have written policies and procedures for assigning each of its enrollees to a primary care provider (PCP). 438.208(b)(1) o Providers who may qualify as PCPs include - Pediatricians; - Family and General Practitioners; - Internists; - Obstetrician/Gynecologists; - Specialists who perform primary care functions, e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or - Other providers approved by the Department. o Enrollees will be provided with the opportunity to choose a PCP affiliated with the MCO. Enrollees residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines must be permitted to choose from at least two PCP providers. o Enrollees who do not request an available PCP prior to the twenty-fifth (25th) day of the

Coordination and Continuity of Care (42CFR 438.208) *
month prior to the enrollment effective date may be assigned to a PCP by the MCO within its network. The MCO will take into consideration such known factors as: - current provider relationships (as indicated on the enrollment broker's Health Status Survey Questionnaire); - language needs (to the extent they are known); - age and gender; - enrollment of family members (e.g., siblings); - and area of residence. o Enrollees who are assigned a PCP are notified in writing by the MCO on or before the first effective date of enrollment and are provided with the PCP's name, location, and office telephone number. o The enrollee must have an assigned PCP from the date of enrollment with the plan. o Enrollees can select or be assigned to a new PCP when requested by the enrollee, when the MCO has terminated a PCP, or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding. - When an enrollee changes his or her PCP, the MCO must make the enrollee's medical records or copies thereof available to the new PCP within ten (10) business days from receipt of request. o Enrollees with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist and the MCO shall grant these PCP requests, as is reasonably feasible and in accordance with the MCO's credentialing policies and procedures o Provider network is supported by written agreements and is sufficient to provide timely and adequate access to all covered services.

*It is assumed that the impending Federal regulations for CHIP managed care will duplicate those for Medicaid managed care.

d) Coverage and authorization of services

The MCOs are required by DMAS to provide services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished to Medicaid/CHIP enrollees who are served through the State's FFS delivery system. Table 4 provides specific requirements of the MCOs to assure DMAS that is providing services in the amount, duration, and scope that, at a minimum, is the same as the State's FFS delivery system.

Table 4

Coverage and Authorization of Services 42CFR 438.210
CFR requires the State to: identify, define, and specify the amount, duration, and scope of each service the MCO is required to offer. **In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:** o Define "medically necessary" as appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical

Coverage and Authorization of Services 42CFR 438.210
practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose; o Determine medical necessity under the supervision of qualified medical professionals and completed within a reasonable period of time after receipt of all necessary information; o Manage service utilization through utilization review, prior authorization, and case management, but not through the establishment of benefit limits for medically necessary services that are more restrictive than those established by Medicaid; o Provide new members with information regarding covered services, authorization and referral processes; o Begin coverage of all covered medical conditions of each enrollee as of the effective date of enrollment with the MCO, regardless of the date on which the condition arose; o Provide, arrange, purchase or otherwise make available all services required under the MCO contract to all enrollees. The comprehensive (but, not all inclusive) list of covered and carved-out services is contained in the appendix (💻) of the MCO contracts.

*It is assumed that the impending Federal regulations for CHIP managed care will duplicate those for Medicaid managed care.

3. Standards on Access to Care for Persons with Special Health Care Needs

A number of processes are in place to promptly identify persons with special health care needs. The process begins during enrollment when a recipient contacts the managed care helpline or the enrollment broker. While the recipient is in the enrollment process, either the broker or the helpline staff conducts a health status assessment (HSA). The assessment is used to identify potential case and condition management needs or conditions which may require medical management intervention, such as high risk pregnancies. These HSAs are sent to the MCO that the enrollee chooses or which is automatically assigned to when the enrollee does not make a choice. The MCO may not always receive a complete HSA on a new enrollee due to a number of administrative barriers during the application process. In those cases, the MCOs are required to make a good faith effort to contact the new enrollee.

Another way individuals with special health care needs are identified is through a monthly report that DMAS provides to each MCO. This report identifies recipients enrolled in home and community based care waiver services; recipients enrolled in the Part C Early Intervention program; and, recipients in disabled and other identified aid categories. Recipients identified by these categories require an assessment by the MCO to determine if follow-up by case management and/or medical management staff is needed. Further, the case manager is expected to assess the type and extent of services needed and how the MCO will coordinate the necessary care.

Table 5 on the next page includes specific requirements of the MCOs that must be met to ensure access to care by person with special health care needs. These access standards are <u>in addition to</u> those provided in Tables 1 – 4 for all enrollees.

Table 5

Standards on Access to Care for Persons with Special Health Care Needs (42CFR 438.208(c))

CFR requires the State to: ensure that each MCO provides primary care and service coordination for enrollees with special health care needs.

In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:

- Provide the medical claims history, when available to the next MCO when an enrollee (including those with special health care needs) changes their membership to a different MCO;
- Have mechanisms in place to identify enrollees with special health care needs, such as: using claims data to identify people with diabetes and other chronic conditions that may require disease management by the MCO; self-referral or referral from a parent, guardian, or provider; or diagnosis codes, such as brain injury or delayed speech;
- Establish and adhere to policies and procedures for enabling enrollees of all ages with special health care needs to:
    - be identified via (but not limited to): HSAs completed by the enrollment broker or helpline, specific aid categories identified via the enrollment file; early intervention utilization reports; and other means such as case management and member complaints or self-referrals.
    - receive an assessment to ascertain their needs;
    - receive assistance from a case manager for appointment scheduling, navigating referral processes to providers and resources, and the option of maintaining ongoing communications with the family throughout the continuum of care;
    - receive coordinated patient care and with particular attention to any complex, serious, or disabling conditions;
    - have in place a case management plan that is developed and maintained by the case manager and is based on the service and coordination needs identified through initial and ongoing assessments;
    - have direct access to a specialist through a standing referral or an approved number of visits;
    - be able to request that a specialist serve as their PCP;
    - have access to disease management programs that focus on improving the health status of enrollees with asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, or diabetes.
- Establish and adhere to procedures for assessing newly enrolled disabled adults (in specified aid categories) within 90 days of initial enrollment;
- Automatically deem children under age 21 in SSI and/or early intervention as having special health care needs;
- Automatically deem children under age 21 as having special health care needs if they have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and who may need health and related services of a type or amount over and above those usually expected for the child of similar age.
- Provide care coordination for CSHCN among the multiple providers, agencies, advocates, and funding sources serving CSHCN

*It is assumed that the impending Federal regulations for CHIP managed care will duplicate those for Medicaid managed care.

IV. State Standards for Structure and Operations

A. Description of State Standards for Structure and Operations

Table 6 describes the standards and assurances required of states, per the CFR, and lists specific requirements that DMAS has of the MCOs for ensuring the State is in compliance.

Table 6

State Standards for Structure and Operations (42CFR 438.214- 230)
CFR requires the State to ensure that each MCO implements policies and procedures for: selecting and retaining qualified providers; protecting the confidentiality of enrollees; identifying and resolving grievances and appeals; and overseeing all subcontractors and holding them accountable for their delegated responsibilities. **In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:** 1) Have credentialing and re-credentialing requirements 438.214 o Credentialing and re-credentialing standards must match the most recent guidelines from NCQA and in be in accordance with 12 VAC 5-408-170 of the Virginia Administrative Code; o Disclosure of provider and contractor information must be in accordance with 42 C.F.R. 455 Subpart B as related to ownership and control, business transactions, and criminal conviction for offenses against Federally related health care programs including Medicare, Medicaid, or CHIP programs; o Ensure that the MCO, contractors, and subcontractor(s) perform, at a minimum, a monthly comparison of its provider network against the LEIE database to ensure compliance with these Federal regulations. 2) Provide enrollees with a handbook that includes information regarding access, member rights, coverage, and authorization of care 438.218 o Provided by the MCO to the enrollee prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, enrollee eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, enrollee services, emergency care, enrollee identification cards, enrollee responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes. 3) Use and disclose identifiable health information only 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 438.224 o Comply, and require compliance by its subcontractors and providers, with HIPAA security and confidentiality of records standards detailed in the contract. o Disclosure or use of information concerning Contract services or enrollees obtained in connection with the performance of the Contract shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements, and

provisions of the American Recovery and Reinvestment Act of 2009, wherein Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L 111-5). Section 13402 of the HITECH Act addresses requirements for business associates under HIPAA regarding Breach Notification.

4) Recognize that DMAS has sole authority and responsibility for enrollment into the managed care program and the MCO is responsible for health benefit management

438.226

- Within certain parameters, contingent upon availability of managed care in a particular region of the State, enrollees are afforded the opportunity to choose their MCO among the plans that are available.
- The MCO shall promptly notify DMAS upon learning that an enrollee meets one or more of the exclusion criteria.
- Disenrollment from managed care by DMAS shall be in accordance with 42 C.F.R. § 438.56(b)(2)&(3).
- The MCO shall notify the enrollee of his or her enrollment in the MCO through a letter sent simultaneously with the enrollee handbook.
- Upon disenrollment from the plan, the MCO shall notify the member through a disenrollment notice that coverage in the MCO will no longer be effective. The disenrollment notice should identify the effective date of disenrollment and, whenever possible, should be mailed prior to the member's actual date of disenrollment.
- The MCO shall be responsible for keeping its network of providers informed of the enrollment status of each enrollee. The Contractor shall be able to report and ensure enrollment to network providers through electronic means.

5) Have processes in place for educating enrollees about and responding to grievances and appeals and for educating enrollees on why and how to access the State's fair hearing system

438.228

- Descriptions of the grievance and appeals procedures including, but not limited to, the issues that may be resolved through the grievance or appeals processes;
- Directions for enrollees to appeal directly to DMAS for a State fair hearing, which includes DMAS address for the appeals; the process for obtaining necessary forms; and procedures and applicable timeframes to register a grievance or appeal with the MCO or with DMAS;
- Availability of assistance in the filing process(es); and,
- The toll-free numbers that the enrollee can use to file a grievance or an appeal by telephone.
- The MCOs must adhere to Subpart F of 42 CFR 438.400 – 438.424 with regards to processes, communications, and timeliness of grievances, appeals, and the right to access the State fair hearing process.

6) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor

438.230

- All subcontracts shall be in writing and include the specific activities and reporting responsibilities delegated to the subcontractor; and, provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate.

State Standards for Structure and Operations (42CFR 438.214- 230)
o The MCO shall be accountable by DMAS for all actions of their subcontractors and providers. o Perform on-going monitoring of all subcontractors and shall assure compliance with subcontract requirements and shall perform a formal review of all subcontractors at least annually. o Monitor the subcontractor's provider enrollment, credentialing, and re-credentialing policies and procedures to assure compliance with Federal disclosure requirements, with respect to disclosure of information regarding ownership and control, business transactions, and criminal convictions for crimes against Federally related health care programs. Additionally, the Contractor shall monitor to assure that the subcontractor complies with requirements for prohibited affiliations with individuals or entities excluded from participating in Federally related health care programs.

*It is assumed that the impending Federal regulations for CHIP managed care will duplicate those for Medicaid managed care.

B. State Standards for Quality Measurement and Improvement

The magnitude of MCOs' adherence to NCQA's standards enables the State to have a managed care delivery system that far exceeds the minimum requirements set forth by the CFR for quality measurement and improvement.

Reader Tip #3

In order to emphasize the value-added benefit of NCQA accreditation as it relates to quality care, Tables 8 – 10 include a section that summarizes relevant NCQA standards.

Table 8

State Standards for Clinical Guidelines (42CFR 438.236)
CFR requires the State to ensure that each MCO has the structure and clinical resources for adopting evidence-based clinical guidelines for meeting the health care needs of enrollees. **In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:** o Provide local medical management through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise to perform case management activities; o Have a full-time, Virginia-based medical director who is a Virginia-licensed medical doctor; o Have medical management staffing at a level that is sufficient to perform all necessary medical assessments and to meet all enrollees' case management needs at all times. **In order for MCOs to meet NCQA standards for the use of clinical guidelines, the MCOs must:**

State Standards for Clinical Guidelines (42CFR 438.236)
• Ensure that practitioners are using relevant clinical practice guidelines; • Establish the clinical basis for the guidelines; • Update the guidelines at least every two years and initiate the review of a guideline before two years if new scientific evidence or national guidelines warrant the need for a review; • Distribute the guidelines to the appropriate practitioners.

*It is assumed that the impending Federal regulations for CHIP managed care will duplicate those for Medicaid managed care.

Table 9

State Standards for Quality Assessment and Performance Improvement (42CFR 438.240)
CFR requires the State to ensure that each MCO has an ongoing quality assessment and performance improvement program for the services provided to enrollees. **In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:** • Annually submit performance measurement data, specifically a sub-set of HEDIS measures pre-selected by DMAS; • Have in effect mechanisms to detect both over and under utilization of services; • Have in effect mechanisms to assess quality and appropriateness of care to enrollees; • Have an internal quality improvement plan (QIP) that meets the accreditation standards of NCQA; • Annually provide DMAS with a quality improvement plan that focuses on improving HEDIS scores that are either below the national average, per NCQA's Quality Compass, or have changed unfavorably by at least five percent from the previous year; - The plan must adhere to the content requirements set forth by the DMAS-created quality improvement template • Fully participate in other quality activities required by DMAS and respond favorably to information and data requests from DMAS or its designated agent (EQRO) in order for resultant reports to be accurate and meaningful; - Annually conduct performance improvement projects (PIPs) to include the HEDIS measures pre-selected by DMAS for the PIPs; adhere to timeframes and milestones set by EQRO in order for the PIPs to be validated. - Allow for the EQRO to conduct a performance measure validation on at least two quality (HEDIS) measures pre-selected by DMAS. - Prepare and provide documentation and evidence of compliance with the CMS published protocol for a comprehensive operational systems review (OSR), which is conducted by the EQRO once every three years. - During the years when the OSR is not conducted, DMAS convenes a team of internal subject matter experts to perform a "modified-OSR" of each MCO. The modified-OSR focuses on those elements identified during the most recent OSR as needing improvement and any critical elements of the MCO contract that may need focused attention.

State Standards for Quality Assessment and Performance Improvement (42CFR 438.240)

- Annually, the EQRO conducts clinical focused studies and the annual technical report.

- Ensure the cooperation of network providers and subcontractors with the EQRO requests for medical records;

In order for MCOs to meet NCQA standards for quality assessment and performance improvement, the MCOs must:

- Have clearly defined quality improvement structures and processes
  - Written description of their QI program;
  - Behavioral health and patient safety is included in the description;
  - Quality improvement program is accountable to a governing body;
  - Designated physician must have substantial involvement in the program;
  - Quality improvement committee must oversee the quality improvement program;
  - Written annual work plan;
  - Description of resources used for the quality improvement program;
  - Objectives for serving a culturally and linguistically diverse membership.
- Follow the NCQA published technical specifications for all HEDIS measures.

*It is assumed that the impending Federal regulations for CHIP managed care will duplicate those for Medicaid managed care.

Table 10

State Standards for Health Information Systems (42CFR 438.242)

CFR requires the State to ensure that each MCO maintains a health information system that collects, analyzes, integrates, and reports data that are accurate, complete and timely to the State.

In order to meet the CFR requirements, MCOs are contractually obligated by DMAS to:

- Accept and process enrollment reports and reconcile them with the MCO enrollment/eligibility file;
- Accept and process provider claims and encounter data within the parameters set forth by DMAS;
- Track provider network composition and access, and grievances and appeals as set forth by DMAS;
- Perform quality improvement activities;
- Furnish DMAS with timely, accurate and complete clinical and administrative information, as set forth in this Contract;
- Ensure that data received from providers is accurate, and complete by verifying the accuracy and timeliness of reported data;
- Screen the data for completeness, logic, and consistency;
- Collect health service information in standardized formats established by DMAS;

State Standards for Health Information Systems (42CFR 438.242)

- In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, assign unique identifiers to providers, including physicians, and require that providers use these identifiers when submitting data to DMAS;
- Make available to DMAS and CMS, upon request, all data collected by the MCO in relation to and in support of the program.
- Include information on utilization, grievances and appeals, and disenrollments for other than loss of Medicaid/CHIP eligibility;
- Accommodate and modify future system changes/enhancements to claims processing or other, related systems as soon as possible after being notified by the State of the change or enhancement;
- Notify DMAS in writing of the anticipated implementation date of the system changes/enhancements;
- Accommodate all future health information system requirements based upon Federal and State statutes, policies and regulations.

In order for MCOs to meet NCQA standards for the use of health information systems, the MCOs must:

- Have the ability to follow all applicable HEDIS technical specifications;
- Perform according to standards on its annual HEDIS compliance audit.

C. State Monitoring and Evaluation

DMAS recognizes the value of having NCQA accredited MCOs deliver the care to Medicaid and CHIP enrollees. The standards that must be met and the rigorous and ongoing evaluation of the MCOs by NCQA provides for the structure, processes and outcomes necessary to deliver quality care to enrollees. DMAS also recognizes the value of efficiencies gained from the ongoing and rigorous accreditation processes that the MCOs experience. The three mandated managed care external quality review activities, as set forth in the Balanced Budget Act, are listed below with a brief explanation on how NCQA accreditation enables the MCOs to automatically meet some of the requirements. The resultant reports from the quality review activities, which are produced by the EQRO, are available upon request. All of the reports are summarized in the Annual Technical Report, which is also produced by the EQRO and is made available on the DMAS web page.

D. Procedures Identifying Race, Ethnicity, and Primary Language of Enrollees

The race, ethnicity, and primary spoken language for most Medicaid/CHIP managed care enrollees is collected during the application process through the applicants local Department of Social Services. The information is then conveyed to DMAS through transfer of the membership information. Upon assignment or selection to an MCO, the new member's race, ethnicity and primary language are included in the enrollment information that is conveyed from DMAS to the respective MCO. The same process for collecting this

information for Medicaid and CHIP as described above is also used for the Supplemental Security Income (SSI) population as well.

The State's race, ethnicity, and primary language categories are as follows:

Adult Applicant Race: White, Asian, Black or African-American, Native Hawaiian/Other Pacific Islander, American Indian/Alaskan Native, Other.

Child Applicant Race: White, Black/African American, American Indian/Alaskan Native, Asian, Spanish American/Hispanic, Native Hawaiian or other Pacific Islander, Asian & White, Black/African-American & White, Other or Unknown or Asian & Black/African-American.

Adult or Child Applicant Ethnicity: Hispanic/Latino or Not Hispanic/Latino.

Adult Applicant Primary Language: English, Farsi, Korean, Vietnamese, Chinese, Haitian-Creole, Laotian, Kurdish, Arabic, Somali, German, French, Japanese, Spanish, Cambodian, Other.

Child Applicant Primary Language: English, Spanish, Vietnamese, Farsi, Korean, Kurdish, Arabic, Urdu, Russian or any other language.

E. National Performance Measures and Levels

CMS is in the process of developing performance measures with suggested levels of bold goals in consultation with States and other relevant stakeholders. As of early 2011, there have not been any national performance measures or levels deemed required by CMS. DMAS will continue to maintain its expectations of the MCOs by requiring HEDIS scores to be calculated, reported, and benchmarked against national averages. At the point CMS undertakes the development of a standardized set of performance measures, States will be engaged throughout each phase of the process. DMAS has, and will continue, to routinely assess the utility and value of adopting performance measures for its Medicaid and CHIP programs and the MCOs. Further, DMAS will remain vigilant in adhering to CMS-required reporting on Medicaid/CHIP MCO performance and will routinely assess the need to integrate new performance measure specifications in the Quality Strategy.

DMAS is monitoring the progress, lessons learned, and best practices experienced by other states that are engaged in pilot projects using proposed and voluntary Medicaid/CHIP managed care performance measures. This qualitative information will enable DMAS to adjust its strategy based on the results of the pilot testing.

The use of quality measures at the provider level through the adoption of electronic health records (EHRs) and through participation in the provider EHR incentive program will enable DMAS to have access to those measures that are contained within the scope of meaningful use.

F. Continuous Improvement

DMAS selects a subset of HEDIS measures for tracking and trending MCO performance and to set benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The HEDIS measures that are a priority for continuous improvement are selected based on the needs of the populations served and the favorable health outcomes that result when the relevant clinical guidelines are adhered to by each MCO's provider network.

The majority of the time, DMAS selects the same measures for a number of years to enable statistically sound trending of data. Trending provides DMAS and the MCOs to further realize the impact of ongoing quality improvement initiatives, rather than basing the effectiveness on just one year's worth of data.

In an effort to continue favorable trends and, or change the course of an unfavorable trend, DMAS requires each MCO to submit a corrective action plan within 30 days after the NCQA publishes Quality Compass. This plan was previously described in Table 8.

If DMAS determines that an MCO has shown significant reductions in performance from previous years or in comparison to their Virginia MCO peers, it may require a more detailed corrective action plan for rapid-cycle improvement. This approach has been very collaborative and effective, and although sanctioning is an option, it has not been necessary.

DMAS and the MCOs recognize that effective quality improvement must be methodical, ongoing, and measureable. Beginning with fiscal year 2012 on each of the DMAS-selected HEDIS measures, DMAS has stretched its previous goal for MCOs to that of reaching the 75th percentile in NCQA's Quality Compass.

While it is not realistic to expect all of the Virginia MCOs to reach the 75th percentile for all of the priority measures, it is feasible to set this stretch goal for 2015. Table 11 delineates the sub-set of HEDIS measures that DMAS includes in the contract as high- volume/high-impact and high priority for improvement. The table also shows Quality Compass 2010 (HEDIS 2010) as the baseline year and how the MCO average compared to the 75th percentile for the same year. All of the 2010 Virginia averages for Medicaid/CHIP managed care are below the 75th percentile, reinforcing the opportunity for improvement.

Table 11 HEDIS Priority Measures with 2010 Averages and Percentiles as Baseline Year for Virginia Medicaid/CHIP Managed Care

HEDIS Measure (abbreviated name)	Virginia MCO Average	* National Medicaid 75th Percentile
Immunizations by Age Two (Combo 2)	71.48	81.51
Well Child Visits Age 15 Months (6 visits)	65.22	69.39
Well Child Visits Ages 3,4,5 and 6 years old (one annual visit)	71.17	77.24
Breast Cancer Screening	46.24	59.58
Adolescent Well Child Visit	44.45	55.90

HEDIS Measure (abbreviated name)	Virginia MCO Average	* National Medicaid 75th Percentile
Timeliness of Prenatal Care	87.68	90.04
Postpartum Care	68.00	70.26
HbA1c Testing for Members with Diabetes	81.02	86.37
Good Control (8%) of HbA1c for Members with Diabetes	49.68	54.22
Eye Exam for Members with Diabetes	48.31	63.69
LDL-C Screen for Members with Diabetes	74.70	80.07
Controlled LDL-C Level (<100mg/dL) among members with Diabetes	33.52	40.88
Medical Attention for Neuropathy for Members with Diabetes	77.90	82.70
Blood Pressure Controlled at <140/90 among Members with Diabetes	61.11	68.23
Blood Pressure Controlled at <130/90 among Members with Diabetes	31.42	36.74
Members with Asthma with Controller Medication	88.67	90.82
LDL-Cholesterol Screening among Members with Cardiovascular Disease (CVD)		
LDL-Cholesterol Controlled among Members with CVD	45.06	50.00
Blood Pressure Controlled among Members with CVD	60.46	84.85
Lead Screening by Age 24 Months	56.56	81.02
Management of Anti-Depressant Medication Use (acute)	49.52	53.18
Management of Anti-Depressant Medication Use (continuation)	33.59	35.36
30-day Follow-up after hospitalization for mental illness	59.73	74.28
7-Day Follow-Up after Hospitalization for Mental Illness	37.73	59.10

* The 2010 national 75th percentile is provided for informational purposes while the actual goal for each measure is to achieve the HEDIS 2015 75th percentile for each.

G. **Collaborative Approach**

The State agency facilitates a quarterly collaborative meeting with all of the Medicaid MCO quality improvement representatives. The meeting enables open discussion on challenges, best practices, and lessons learned. The case study in Appendix F - Improving Childhood Immunization Rates - demonstrates how DMAS works in collaboration with the MCOs to improve the health of the populations served.

H. Intermediate Sanctions

Even though DMAS cultivates a culture of collaboration with the MCOs, DMAS recognizes the importance of having a Medicaid/CHIP managed care delivery system that is structured to provide accessible, timely and quality focused healthcare. The contract between the State and each MCO is designed to delineate the regulatory and state specific performance expectations of the MCO. Even further, it is DMAS' responsibility to monitor each MCO's compliance with the contract and to respond promptly and effectively if an MCO fails to meet certain standards.

Section 1932(e)(1)(A) of the Social Security Act (the Act) describes the use of intermediate sanctions for States. Intermediate sanctions may be imposed if the managed care organization:

1) fails to substantially provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the Contract;

2) imposes premiums or charges enrollees in excess of the premiums or charges Permitted by Title XIX of the Act;

3) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX of the Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

4) fails to comply with the physician incentive requirements under section 1903(m)(2)(A)(x) of the Act; or,

5) misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, enrollee, potential enrollee, or health care provider.

Intermediate sanctions include:

1) Civil money penalties
2) The appointment of temporary management
3) Permitting individuals enrolled with the MCO to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment
4) Suspension or default of all enrollment of individuals
5) Suspension of payment to the MCO

In addition to *intermediate* sanctions, there are provisions in the MCO contract that address sanctions if an MCO repeatedly fails to meet certain standards and finally, provisions that give DMAS the authority to terminate the contract.

DMAS stands prepared to respond quickly, carefully, appropriately, and when necessary and in the best interest of eligible Virginians, should any circumstances arise.

Conclusion

Virginia's Medicaid and CHIP enrollees who are served through the managed care delivery system are receiving care that far exceeds the minimum standards from the Federal government for structure, process and outcomes. The MCOs are held to the highest industry standards as evidenced by the DMAS-requirement of NCQA accreditation, and ongoing assessment by the EQRO. Further, there is always room for improvement so long as any measures of performance fall short. Until the

managed care quality vision of providing the right care, in the right way, at the right time, EVERY TIME, is achieved, DMAS and the MCOs will continuously partner to improve the structure, process, and outcomes of care.

DMAS will use this strategy, in partnership with the MCOs, for designing and implementing incremental steps toward achieving bold goals that will result in optimal health for the populations served.

APPENDIX A

CMS Guidelines for State Managed Care Quality Strategy

Required Elements to Be Included in
State Quality Assessment & Improvement Strategies
December 2009

Each State must submit to CMS:

- a copy of the initial strategy; a copy of the revised strategy whenever significant changes are made; and regular reports on the implementation and effectiveness of the strategy.

The quality strategy must include:

I. Process for quality strategy development, review, and revision	**Section of State Quality Strategy in Which Requirement Should Be Addressed**
A. A description of the process the State will use for the development of the quality strategy.	Introduction
B. A description of the formal process the State will use to obtain beneficiary and stakeholder input and public comment before final adoption in final.	Introduction
C. A description of how and how often the State will conduct periodic reviews of the effectiveness of the strategy.	Review of Quality Strategy
D. The State's definition of "significant changes" to strategy that will trigger shareholder input.	Review of Quality Strategy
E. The State's timeframes for updating the quality strategy.	Review of Quality Strategy
II. Managed care program goals and objectives	
A description of the goals and objectives of the State's managed care program, including priorities, strategic partnerships, etc.	Introduction
III. CHIP contract provisions	Assessment
Either: 1) the provisions in the State's Medicaid MCO and PIHP contracts that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement, or 2) a summary description of the contract provisions in its CHIP MCO and PIHP contracts that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement. If the State chooses the latter option, the description must be sufficiently detailed to offer a clear picture of the specific contract provisions.	

IV. State standards for access to care	Assessment
A. A summary description of the State standards for access to care with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as regulations including—	
1. Availability of Services a) Maintains and monitors a network of appropriate providers. b) Provides female enrollees with direct access to a women's health specialist. c) Provides for a second opinion from a qualified health care professional. d) Must provide necessary services that are not available in the network. e) Requires out of network providers to coordinate with the MCO or PIHP with respect to payment. f) Demonstrates that providers are credentialed. g) Timely access. h) Cultural considerations.	
2. Assurances of adequate capacity and services a) Offers an appropriate range of preventative, primary care, and specialty services. b) Maintains a network of providers that is sufficient in number, mix, and geographic distribution.	
3. Coordination and continuity of care a) Ensure that each enrollee has an ongoing source of primary care, b) Coordinate all services that the enrollee receives, c) Share identification and assessment information to prevent duplication of services for individuals with special health care needs. d) Protect the enrollees privacy in the process of coordinating care e) Additional services for persons with special health care needs, including: i. Identification; ii. Assessment; iii. Treatment plans; and iv. Direct access to specialists.	
4. Coverage and authorization of services a) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, and PAHP is required to offer. b) Specify what constitutes "medically necessary	

services". c) That the MCO, PIHP, or PAHP have in place and follow written policies and procedures for authorization of services. d) That any decision to deny a service be made by an appropriate health care professional.	
B. Detailed information related to the access to care standards, including— Identification of mechanisms the State uses to identify persons with special health care needs to MCOs, PIHPs, and PAHPs. Identification of standards the State uses to determine the extent to which treatment plans are required to be produced by MCOs, PIHPs, and PAHPs for individuals with special health care needs.	
V. State standards for structure and operations	Assessment
A. A summary description of the State standards for structure and operations with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in regulation including— 1. Provider selection a) Each State must establish a uniform credentialing and recredentialing policy 2. Enrollee information 3. Confidentiality 4. Enrollment and disenrollment 5. Grievance system 6. Subcontractual relationship and delegation a) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor	
B. Detailed information related to the structure and operation standards, including— 1. State procedures for the review of the records of MCO and PIHP grievances and appeals, and for identifying and resolving systemic problems.	
VI. State standards for quality measurement and improvement	Assessment
A. A summary description of the State standards for quality measurement and improvement with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in regulation including—	
1. Practice guidelines a) Based on valid and reliable clinical evidence. b) Consider the needs of MCO's, PIHP's, and PAHP's enrollees.	

c) Adopted in consultation with contracting health care professionals. d) Reviewed and updated as appropriate.	
2. Quality assessment and performance improvement program a) Conduct performance improvement projects. b) Submit performance measurement data. c) Have in effect mechanisms to detect both overutilization and underutilization of services. d) Have in effect mechanisms to assess quality and appropriateness of care to enrollees. e) Measure performance and/or report performance data to the State. f) Report the status and results of each project to the State as requested. g) State must review at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program.	
3. Health Information Systems a) Collect data on enrollee and provider characteristics as specified by the State. b) Ensure the data received from providers is accurate and complete. c) Make all collected data available to the State and upon request to CMS.	
B. Detailed information related to the quality measurement and improvement standards, including—	
1. A description of the methods and timeframes to assess the quality and appropriateness of care and services to all CHIP beneficiaries.	
2. An identification of the populations the State will consider when determining individuals with special health care needs.	
3. The State standards for the identification and assessment of individuals with special health care needs.	
4. Procedures the State will use to separately assess the quality and appropriateness of care and services furnished under the State's MCO and PIHP contracts to all Medicaid enrollees and to individuals with special health care needs.	
5. A description of the State's information system(s) and how these systems support the initial and ongoing operation and review of the State's quality strategy; for example, a description of how the State intends to use its MMIS and any other system to monitor quality, produce reports on performance indicators, collect data on different quality measures, etc..	

VII. State monitoring and evaluation	Assessment
A description of how the State will regularly monitor and evaluate MCO and PIHP compliance with the State-established standards for access to care, structure and operations, and quality measurement and improvement; this may include for example, a description of the types of reviews the State will perform, how often it will monitor these standards, and how the results of the State's efforts will be reported.	
A. Arrangements for external quality reviews A description of the State's arrangements for an annual, independent external quality review of the timeliness, outcomes, and accessibility of the services covered under each MCO and PIHP contract. This section should include a broad description of the scope of the contract (e.g., calculating HEDIS measures or designing performance improvement projects), including the term of the contract.	
B. Nonduplication of mandatory external quality review activity A description of the standards and activities that will be monitored through the use of Medicare or private accreditation review information and an explanation of the rationale for why the State review would be duplicative of review activity already performed.	
VIII. Procedures for race, ethnicity, and primary language A. A description of how the State identifies the race, ethnicity, and primary spoken language of each Medicaid MCO and PIHP enrollee and how it will provide this information on each Medicaid enrollee to the MCO and/ or PIHP at the time of enrollment.	Assessment
B. A description of the State's efforts to collect information on ethnicity and primary language spoken for any beneficiaries receiving Supplemental Security Income, as this information is not available from the Social Security Administration.	
C. An identification of the State's race, ethnicity, and primary language categories, including a description of how it defines and categorizes "ethnicity".	
IX. National performance measures and levels	**Assessment**
For MCOs and PIHPs, the performance measures and levels developed by CMS in consultation with States and other relevant stakeholders. (Note: at this time no performance measures and levels have been developed. At the point CMS undertakes their development; the States will be consulted in each phase of the development process, including the	

specification of the level of information to be included in the State's quality strategy.)	
X. Intermediate sanctions	**Improvement**
For MCOs only, a description of how the State uses intermediate sanctions in support of its quality strategy. These sanctions must, at a minimum, meet the requirements specified in regulation. The State's description should specify its methodology for using sanctions as a vehicle for addressing identified quality of care problems.	

NOTE: While including these elements in the State Quality Strategy satisfies Federal regulatory requirements, additional elements referenced in the "State Quality Strategy Tool Kit for State Medicaid and Children's Health Insurance Agencies" should also be incorporated to ensure that the Strategy is comprehensive and coherent.

APPENDIX B

Screen shot from Virginia Regulatory Town Hall
request for public comment

Agency Department of Medical Assistance Services

Board Board of Medical Assistance Services

General Notice

DMAS Draft 2011 Managed Care Quality Strategy for Public Comment

Date Posted: 2/23/2011

Expiration Date: 3/25/2011

Submitted to Registrar for publication: YES

Department of Medical Assistance Services (DMAS)

In accordance with the requirements of the federal Medicaid authority, the Centers for Medicare and Medicaid Services (CMS), the Department of Medical Assistance Services gives Notice that the Agency is publishing for public comment a draft of the DMAS 2011 Managed Care Quality Strategy. The Code of Federal Regulations, specifically 42 C.F.R. § 438.202, requires states that contract with Managed Care Organizations (MCOs) to have a written strategy for assessing and improving the quality of managed care services offered by all MCOs. It also requires those states to obtain the input of recipients and other stakeholders in the development of the strategy and to make the strategy available for public comment before adopting it in final. The purpose of this Notice is to fulfill that requirement.

A copy of the DMAS Draft 2011 Managed Care Quality Strategy may be viewed on the DMAS web site at the following address:

http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-qs.pdf

This Notice is being made available for comment by interested parties through March 25, 2011. Following this public notice period, DMAS shall take into consideration the public comments received by the Agency and submit the final draft of the 2011 Managed Care Quality Strategy to the Centers for Medicare & Medicaid Services for approval. Anyone wishing to provide public comment on the DMAS Draft 2011 Managed Care Quality Strategy may submit their comments to:

Carol L. Stanley, MS, CPHQ
Quality Improvement Analyst
Virginia Department of Medical Assistance Service
Division of Health Care Services
Suite 1300, 600 East Broad Street
Richmond, Virginia 23219
Phone (804) 371-7980
Carol.Stanley@dmas.virginia.gov

Contact Information

APPENDIX C

Letter with comments received from the Virginia Association of Community Services Boards, Inc.

and

Response letter from DMAS to the Virginia Association of Community Services Boards, Inc.

VACSB Review and Recommendations for Behavioral Health Measures and Outcomes listed in DMAS Managed Care Quality Strategy Draft 2nd Edition

Overview of Behavioral Health Measures and Outcomes

Overall, the DMAS Draft 2nd Edition lists performance standards, time to services, distance, range of services, cites NCQA and HEDIS. In the DMAS 2nd draft:

1. Behavioral Health is first mentioned on page 17 second circle from the bottom
2. Page 22 mentions behavioral health and patient safety, top text box
3. NCQA HEDIS performance measures for behavioral health:

    1. Follow up appointment with a psychiatrist following an inpatient psychiatric hospitalization
    2. Follow up appointment when an antidepressant is prescribed by any physician, including a PCP.
    3. Follow up appointments for children prescribed medication for ADHD.
    4. 2009 HEDIS Measures Required as Part of the NCQA Accreditation Process for Medicare Health Plans:

        - Annual Monitoring for Patients on Persistent Medications
        - Antidepressant Medication Management
        - In addition, there are other HEDIS measures that can have a positive outcome on persons with mental illness and co-occurring SA, along with access to primary-dental health care

Recommended Behavioral Health Improvements to the Draft

1. As more blind, elderly and disabled come under managed care, available research estimates 30-40% of these individual have a mental illness, substance abuse, or both, and major primary health care needs
2. The current national dialogue on accountable-care organizations acknowledges increasing attention must be paid to the overall health and wellbeing of the people who are served and recognition that in order to improve all healthcare, quality mental health and substance use services must also be included. Additionally, the role of behavior and lifestyle choices in health improvement and disease management of chronic conditions have been fostered.
3. VACSB recommends adding additional behavioral health measures, such as

    - Use behavioral health assessment instruments measuring symptom and level of care needs, medical necessity criteria based on best practice
    - Improve primary and behavioral health outcomes
    - Specialized Services and measuring outcomes for additional persons being covered under DMAS managed care, such as
        - Adults with Serious Mental Illness
        - Children and Adolescents with Emotional Disturbances
        - Older Adults with Mental Illness
        - Persons with Co-Occurring Disorders, (Mental Health and Substance Abuse)
        - Mental Health Care for Persons with Chronic Medical Illness
        - Individual Reports on Competencies for Working with Culturally Distinct Groups of Persons with Mental Illness

The VACSB stands ready and willing to assist in bringing experience with special populations to efforts that will target meaningful **outcome measures** around special populations who are among the most disabled and most vulnerable in Virginia.

May 24, 2011

Mary Ann Bergeron
Executive Director
Virginia Association of Community Services Boards (VACSB)
10128-B West Broad Street
Glen Allen, Virginia 23060

Dear Ms. Bergeron,

Thank you for submitting your concerns and recommendations on the proposed 2011 – 2015 Managed Care Quality Strategy.

The Department of Medical Assistance Services (DMAS) shares the Virginia Association of Community Services Boards' (VACSB's) and the Community Services Boards' commitment to providing quality behavioral health services to Medicaid and CHIP recipients. The Department also shares the perspective that it is important to provide quality services across the entire continuum of care.

Feedback from the VACSB is timely given several budget items included in the 2011 Appropriations Act that relate to behavioral health services and DMAS' efforts to prepare for the policy and program changes that need to occur as a result of federal health care reform. The concerns and recommendations included in your letter will be taken into consideration as the Department moves forward with these important initiatives.

Your letter has been shared within the Department as a point of reference. Furthermore, DMAS will include your letter dated March 23, 2011in the Appendix of the 2011 – 2015 Managed Care Quality Strategy.

Going forward, the Quality Strategy would be posted for public comment again if significant policy changes occur that would warrant revisions to the Strategy.

Thank you again for your feedback.

Sincerely,

H. Bryan Tomlinson, II
Director
Division of Health Care Services

APPENDIX D

Letter with comments received from the Virginia Association of Centers for Independent Living

and

Response letter from DMAS to the Virginia Association of Centers for Independent Living

Dear Ms. Stanley:

The Virginia Association of Centers for Independent Living offers the following comments on the draft *Managed Care Quality Strategy 2011-2015*.

A Medicaid managed care model of integrated acute and long term care services could be beneficial to people with disabilities. Providing effective care coordination could reduce the occurrence of secondary disabilities and health care conditions that require hospitalization or undesired institutionalization. Care coordination could also improve opportunities for linking to carved out and specialized services. However, before managed care can be expanded to people with disabilities there are significant questions and concerns that must be explored.

VACIL would like to know the estimated number of people DMAS expects to be impacted by an expansion of managed care and characteristics (age, disability, geographical location and if currently enrolled in long term care, what long term care program) of the people expected to be impacted.

VACIL assumes that an expansion of managed care is being pursued, in part, to reduce the overall cost of Medicaid expenditures. Where cost savings are anticipated to be realized and how will services be improved and expanded?

The *Strategy* uses the terms health care condition, disability, illness, special health care needs and medical care conditions. It is difficult to understand why a specific term is being used in a specific context in the document.

VACIL recommends that the following be incorporated into the *Strategy*:

When people with disabilities are being enrolled into managed care the following factors should be incorporated into the assessment:

- Need for and access to durable medical equipment.
- Need for and access to mental health services.
- Access to long term care services that minimally include the long term care services currently available in the home and community based Waivers and the Money Follows the Person demonstration project.
- Acknowledgement of, respect for, and incorporation of planning activities that recognize people with disabilities want to be independent, in control of their lives, active in their communities and to remain productive and healthy.

Access and nondiscriminatory practices and assurances must be clearly outlined to ensure the following:

- Assurances of compliance with the Americans with Disabilities Act and Rehabilitation Act.
- Transportation providers have appropriate transportation equipment, well trained staff and accessible vehicles.
- Material provided in alternative formats.
- Provision of effective communication.

- There will be a need to provide significant education and informative materials to people with disabilities who are accustomed to the current Medicaid fee for service and long term care service delivery system. New terminology and process must be adequately explained before people with disabilities can be expected to select an MCO and before any service change begins on an individual basis. If the expansion of managed care will include people who are dually eligible for Medicare and Medicaid, education efforts and materials should be developed to ensure they adequately address specific issues of importance to people who are dually eligible.

The development of the *Strategy* should include the following:

- Development of a survey to collect information from MCOs to determine their readiness to provide case management/care coordination and other services to people with disabilities. The results of this survey should be available to the public. The survey should include items such as access to medical equipment (exam tables, diagnostic equipment and office locations) and experience providing effective communication with people with disabilities.
- Gradual phase in of new managed care provisions.
- Description of the prevalence and complexity of disability related needs and how these specific needs will be met.
- Development of standards for services to people with low incident disabilities.

The DMAS quality framework used to ensure Managed care quality assessment should include the following MCO performance standards:

- Demonstrated successful experience providing services to people with disabilities who have traditionally been carved out of managed care.
- Demonstrated successful experience providing services to children with significant disabilities through Early and Periodic Screening, Diagnosis and Treatment.
- Development of a transparent process that is understandable to people with disabilities about the process to obtain carved out services, specialized services and services out of network when needed. The process should make clear how a determination is made by the MCO if a service will be provided by the MCO, carved out, provided by a specialist, provided by an out of network provider as an exception, and how an appeal is pursued.
- Staff training to increase their ability to work with people with disabilities who will be advocacy oriented, in control of their services and who are users of services needed to ensure they are able to live independently.
- Development and use of a sufficient network of providers to meet the unique needs of people with disabilities.
- Assurance that consumer directed services will be provided at a minimum for personal care and respite services.
- Production of demographic information about people with disabilities in the geographical area to be served to ensure the MCO has adequately developed their network of providers.

The methods of reviewing the *Strategy* for effectiveness should include the following:

- A monitoring tool to determine how the influx of people with disabilities into managed care has impacted access to care and the quality of care provided.
- A report of findings from an annual survey of recipients. The survey should include feedback on issues related to physical and communication access, access to specialists and

responses from people who have moved into managed care in that specific year surveyed. The findings should be disaggregated by disability, age and geographical area.
- Report on the prevalence of use of specialists and out of network providers.
- Quality indicators should describe how DMAS will ensure adequate consideration of the large number of people with disabilities who will be changing from fee for service to managed care.

Please contact me if clarification is needed about these recommendations. Thank you for this opportunity to provide comment on the draft *Managed Care Quality Strategy 2011-2015*.

Sincerely,
Maureen Hollowell
Virginia Association of Centers for Independent Living
6300 E. Virginia Beach Blvd
Norfolk, VA 23502
757-351-1584
mhollowell@endependence.org

May 24, 2011

Maureen Hollowell
Virginia Association of Centers for Independent Living
6300 E. Virginia Beach Blvd
Norfolk, Virginia 23502

Dear Ms. Hollowell,

Thank you for submitting your suggestions on the proposed 2011 – 2015 Managed Care Quality Strategy. The Department of Medical Assistance Services (DMAS) recognizes the Virginia Association of Centers for Independent Living's (VACIL's) interest in continuously improving the care and services received by Medicaid and CHIP enrollees.

The VACIL's recommendations for monitoring quality are timely given the 2011 Appropriations Act and the potential impact on the health services and DMAS' efforts to prepare for the policy and program changes that need to occur as a result of federal health care reform. The comments and recommendations included in your letter will be taken into consideration as the Department moves forward with these important initiatives.

Your letter has been shared within the Department as a point of reference. Furthermore, DMAS will include your letter dated March 25, 2011in the Appendix of the 2011 – 2015 Managed Care Quality Strategy.

Going forward, the Quality Strategy would be posted for public comment again if significant policy changes occur that would warrant revisions to the Strategy.

Thank you again for your feedback.

Sincerely,

H. Bryan Tomlinson, II
Director
Division of Health Care Services

APPENDIX E

2011 Operational Systems Review
NCQA and CMS Standards

&

Performance Improvement Project Validation

Deeming Matrices

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
Subpart C - Enrollee Rights and Protections ER					
438.100.b.2.i	ER	1			The MCO must provide to the enrollees written information in a manner and format that may be easily understood.
438.10.b.	ER	1	a	Deemed	The MCO must provide to the enrollees all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
438.10.c.3	ER	1	b	Not Deemed	The MCO must make its written information available in the prevalent non-English languages in its particular service area.
438.10.c.4	ER	1	c	Deemed	The MCO must make oral interpretation services available free of charge to enrollees and potential enrollees, for all non-English languages, not just those the State identifies as prevalent.
438.10.c.5.i	ER	1	d	Not Deemed	The MCO must notify its enrollees that oral interpretation is available for any language and that written information is available in prevalent languages.
438.10.c.5.ii	ER	1	e	Not Deemed	The MCO must inform its enrollees of the ways to access oral interpretation services and the written information in prevalent languages.
438.10.d.1.ii	ER	1	f	Not Deemed	The MCO must make all written material for enrollees available in alternative formats that are appropriate for meeting the special needs of those who, for example, are visually limited or have limited reading proficiency.
438.10.d.2	ER	1	g	Not Deemed	The MCO must inform all enrollees and potential enrollees that information is available in alternative formats and indicate how to access those formats.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.10.f	ER	2			The MCO must make information on providers available to the enrollees upon enrollment and annually thereafter, and give enrollees reasonable notice of any changes regarding providers.
438.10.f.3	ER	2	a	Not Deemed	The MCO must furnish to each enrollee the names, locations, and telephone numbers of current contracted providers in the enrollee's service area, as well as the non-English languages spoken by those providers, and identify providers that are not accepting new patients, within a reasonable time after the MCO receives notice of the person's enrollment.
438.10.f.2	ER	2	b	Not Deemed	The MCO must furnish to each of its enrollees, at least once a year, the names, locations, and telephone numbers of current contracted providers in the enrollee's service area, as well as the non-English languages spoken by those providers, and inform them of providers that are not accepting new patients.
438.10.f.4	ER	2	c	Not Deemed	The MCO must furnish to each of its enrollees written notice of any change in the names, locations, telephone numbers of and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients, at least 30 days before the intended effective date of the change.
438.10.f.5	ER	2	d	Not Deemed	This information should include, at a minimum, information on primary care physicians, specialists, and hospitals. The MCO must make a good-faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.
438.10.f.6.ii	ER	2	e	Not Deemed	The MCO must provide information on any restrictions on the enrollee's freedom of choice among network providers.
438.10.f.6.iii	ER	3			The MCO must provide to enrollees information on enrollee rights and responsibilities.
438.100.b.2.ii	ER	3	a	Not Deemed	The MCO must uphold each enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.100.b.2.iii	ER	3	b	Not Deemed	The MCO must uphold each enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
438.100.b.2.iv	ER	3	c	Not Deemed	The MCO must uphold each enrollee's' right to participate in decisions regarding his or her health care, including the right to refuse treatment.
438.100.b.2.v	ER	3	D	Not Deemed	The MCO must uphold each enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
438.10.f.6.iii	ER	3	E		The MCO must provide information on enrollee rights and responsibilities to the enrollee upon enrollment, annually, and at least 30 days prior to any change in benefit.
438.10.f.6.iv	ER	4		Deemed	The MCO inform enrollees about grievance and fair hearing procedures to the enrollee upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.v	ER	5			The MCO must inform enrollees about benefits available to the enrollee upon enrollment, annually, and at least 30 days prior to any change in benefits.
438.10.f.6.v	ER	5	a	Deemed	The MCO must inform enrollees about the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.vi	ER	5	b	Deemed	The MCO must inform enrollees about procedures for obtaining benefits, including authorization requirements, upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.vii	ER	5	c	Deemed	The MCO must inform enrollees about the extent to which, and how, they may obtain benefits, including family planning services, from out-of-network providers, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.x	ER	5	d	Deemed	The MCO must inform enrollees about the policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.xi	ER	5	e	Deemed	The MCO must inform enrollees about cost sharing, if any, and do so upon enrollment, annually, and at least 30 days prior to any change.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.10.f.6.xii	ER	5	f	Not Deemed	The MCO must inform enrollees about how and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.viii	ER	6			The MCO must inform enrollees about after-hours and emergency coverage and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.viii	ER	6	a	Deemed	The MCO must inform enrollees about the extent to which, and how, after-hours coverage and emergency coverage are provided and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.viii.A	ER	6	b	Deemed	The MCO must provide information to enrollees defining the terms *emergency medical condition*, *emergency services*, and *post-stabilization services*, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.viii.B	ER	6	c	Deemed	The MCO must inform enrollees about the fact that prior authorization is not required for emergency services, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.viii.C	ER	6	d	Deemed	The MCO must inform enrollees about the process and procedure for obtaining emergency services, including use of the 911 telephone system or its local equivalent, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.viii.D	ER	6	e	Deemed	The MCO must inform enrollees about the locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.viii.D	ER	6	f	Deemed	The MCO must provide information to enrollees regarding the fact that they have the right to use any hospital or other setting for emergency care, and do so upon enrollment, annually, and at least 30 days prior to any change.
438.10.f.6.ix	ER	6	g	Not Deemed	The MCO must inform enrollees about the post-stabilization care service rules, and do so upon enrollment, annually, and at least 30 days prior to any change.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.10.g.1	ER	7			The MCO must provide information to its enrollees on grievance, appeal, and fair hearing procedures and time frames in a State-developed or State-approved description.
438.10.g.1.i.A	ER	7	a	Deemed	The MCO must inform enrollees that they have rights to a State Fair Hearing.
438.10.g.1.i.B	ER	7	b	Deemed	The MCO must inform enrollees about the methods for obtaining State Fair Hearings.
438.10.g.1.i.C	ER	7	c	Deemed	The MCO must inform enrollees regarding the rules that govern representation at State Fair Hearings.
438.10.g.1.ii	ER	7	d	Deemed	The MCO must inform enrollees regarding their rights to file grievances and appeals.
438.10.g.1.iii	ER	7	e	Deemed	The MCO must inform enrollees regarding the requirements and time frames for filing a grievance or appeal. The MCO must inform enrollees regarding the availability of assistance in the filing process.
438.10.g.1.iv	ER	7	f	Not Deemed	The MCO must inform enrollees regarding the availability of assistance in the filing process.
438.10.g.1.v	ER	7	g	Not Deemed	The MCO must provide enrollees with a toll-free number that the enrollee can use to file a grievance or an appeal by telephone.
438.10.g.1.vi.A	ER	7	h	Not Deemed	The MCO must inform enrollees that benefits will continue if the enrollee files an appeal or a request for a State Fair Hearing within the time period specified for filing.
438.10.g.1.vi.B	ER	7	i	Not Deemed	The MCO must inform enrollees that the enrollee may be required to pay the cost of services furnished while the appeal was pending, if the final decision is adverse to the enrollee.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.10.g.1.vii	ER	7	j	Not Deemed	The MCO must inform enrollees regarding any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
438.10.g.2	ER	8			The MCO must provide information to enrollees regarding advance directives.
438.6.i.1	ER	8	a	Not Deemed	The MCO must maintain written policies and procedures with respect to advance directives.
438.6.i.2	ER	8	b	Not Deemed	The MCO must provide adult enrollees with written information on advance directives policies and include a description of applicable state law.
438.6.i.3	ER	8	c	Not Deemed	The MCO must provide adult enrollees with information that reflects changes in State law regarding advance directives as soon as possible, but no later than 90 days after the effective date of the change.
438.10.g.3	ER	9		Not Deemed	The MCO must provide information to their enrollees regarding physician incentive plans.
438.106	ER	10			The MCO must ensure that its Medicaid enrollees are not held liable for any debts of the MCO or payments for covered services.
438.106.a	ER	10	a	Not Deemed	The MCO must ensure that its Medicaid enrollees are not held liable for the MCO's debts in the event of the MCO's insolvency.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.106.b	ER	10	b	Not Deemed	The MCO's policies must ensure that its Medicaid enrollees are not held liable for any covered services provided to them.
438.106.c	ER	10	c	Not Deemed	The MCO's policies must ensure that its Medicaid enrollees are not held liable for charges for covered services, furnished under a contract, referral, or other arrangement, over and above the amount that the enrollee would owe if the MCO provided the services directly.
438.102.a.1	ER	11		Not Deemed	The MCO may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.
Subpart F: Grievance System GS					
438.402.a	GS	1			The MCO must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system.
438.402.b.1.i	GS	1	a	Deemed	The MCO's grievance process must detail how an enrollee can file a grievance or an MCO-level appeal or request a State Fair Hearing.
438.402.b.1.ii	GS	1	b	Deemed	The MCO's grievance process must detail how a provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal.
438.402.b.1.ii	GS	1	c	Deemed	The MCO's grievance process must detail how a provider may file a grievance or request a State Fair Hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.
438.402.b	GS	2			The MCO's grievance process must be timely.
438.402.b.2.i	GS	2	a	Deemed	The enrollee or the provider may file an appeal no less than 20 days and not to exceed90 days from the date on the MCO's notice of action.
438.402.b.2.ii	GS	2	b	Deemed	The enrollee may request a State Fair Hearing, in a state that does not require exhaustion of MCO-level appeals, no less than 20 days and not to exceed 90 days from the date on the MCO's notice of action.
438.402.b.3.i	GS	3			The MCO must maintain written requirements regarding the filing of a grievance.
438.402.b.3.i	GS	3	a	Deemed	The MCO's grievance procedures must describe how an enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO.

438.402.b.3.ii	GS	3	b	Deemed	The MCO's grievance procedures must describe how an enrollee or a provider may initiate an appeal either orally or in writing but, unless requesting expedited resolution, must follow an oral filing with a written, signed appeal.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.404.a	GS	4			The MCO must provide a written notice of action for grievances that meets state and federal language and format requirements.
438.10.c.1	GS	4	a	Not Deemed	The MCO must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State.
438.10.c.3	GS	4	b	Not Deemed	The MCO's notice of action for grievances must be written in the prevalent languages spoken by enrollees and potential enrollees throughout the State.
438.10.c.4	GS	4	c	Not Deemed	The MCO must make services such as oral interpretation services available free of charge to each enrollee and potential enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.
438.10.c.5.i	GS	4	d	Not Deemed	The MCO must notify its enrollees that oral interpretation is available for any language and that written information is available in prevalent languages.
438.10.c.5.ii	GS	4	e	Not Deemed	The MCO must advise enrollees and potential enrollees about how to access the oral interpretation services and alternative language formats.
438.10.d.1.i	GS	4	f	Not Deemed	The MCO's notice of action must be written in easily understood language and format.
438.10.d.1.ii	GS	4	g	Not Deemed	The MCO's notice of action must be available in alternative formats and in a manner appropriate to meet the special needs of those who, for example, are visually impaired or have limited reading proficiency.
438.10.d.2	GS	4	h	Not Deemed	The MCO must inform all enrollees and potential enrollees that information is available in alternative formats and explain how to access those formats.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.404.b	GS	5			The MCO must adhere to the State's regulations regarding the content of the notice of action.
438.404.b.1	GS	5	a	Not Deemed	The MCO's written notice of action must explain the action the MCO or its contractor has taken or intends to take.
438.404.b.2	GS	5	b	Not Deemed	The MCO's written notice of action must explain the reasons for the action.
438.404.b.3	GS	5	c	Not Deemed	The MCO's written notice of action must explain the enrollee's or the provider's right to file an MCO appeal.
438.404.b.4	GS	5	d	Not Deemed	The MCO's written notice of action must explain the enrollee's right to request a State Fair Hearing, if the State does not require the enrollee to exhaust the MCO-level appeal procedures.
438.404.b.5	GS	5	e	Not Deemed	The MCO's written notice of action must explain the procedures for exercising the rights of appeal, expedited appeal, and fair hearing.
438.404.b.6	GS	5	f	Not Deemed	The MCO's written notice of action must explain the circumstances under which expedited resolution is available and how to request it.
438.404.b.7	GS	5	g	Not Deemed	The MCO's written notice of action must explain the enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of services rendered.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.404.c	GS	6			The MCO's written notice of action for termination, suspension, or reduction of previously authorized Medicaid-covered service must be mailed timely.
431.211	GS	6	a	Not Deemed	The MCO must mail a notice at least 10 days before the date of action, except as permitted under42 CFR § 431.213 and 431.214.
438.210.d.1	GS	6	b	Not Deemed	The MCO must provide standard authorization decision notices as expeditiously as the enrollee's health condition requires and within State-established time periods that not may exceed 14 calendar days following receipt of the request for service, with a possible extension.
438.210.d.4.i	GS	6	c	Not Deemed	If the time for issuing a decision is extended in accordance with 42 CFR § 438.210.d.1, the MCO must give the enrollee written notice of the reason for such an extension and inform the enrollee of the right to file a grievance if he or she disagrees with the decision to extend the time allowed for issuing the authorization decision.
438.210.d.4.ii	GS	6	d	Not Deemed	If the time for issuing a decision is extended in accordance with 42 CFR § 438.210.d.1, the MCO must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date on which the extension expires.
438.210.d.5	GS	6	e	Not Deemed	For service authorization decisions not reached within the periods specified in 42 CFR §438.210.d, a decision must be made on the date on which the extended period expires.
438.210.d.6	GS	6	f	Not Deemed	For expedited service authorization decisions, a decision must be made within the time periods specified in 42 CFR § 438.210.d.2.
438.406.a	GS	7			The MCO must handle grievances and appeals according to regulations.
438.406.a.1	GS	7	a	Not Deemed	The MCO, in handling grievance and appeals, must give enrollees any reasonable assistance in completing forms and taking other procedural steps. Such assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
438.406.a.2	GS	7	b	Not Deemed	The MCO must acknowledge receipt of each grievance and appeal.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.406.a.3.i	GS	7	c	Not Deemed	The MCO must ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making concerning the case at issue.
438.406.a.3.ii	GS	7	d	Not Deemed	The MCO must ensure that the individuals who make decisions on grievances and appeals are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease, if deciding an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal that involves clinical issues.
438.406.b.1	GS	7	e	Not Deemed	The MCO's policies and procedures must provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or provider requests expedited resolution.
438.406.b.2	GS	7	f	Not Deemed	The MCO must offer the enrollee a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The MCO must inform the enrollee of the limited time available for such showing in the case of expedited resolution.
438.406.b.3	GS	7	g	Not Deemed	The MCO must offer the enrollee and his or her representative an opportunity, before and during the appeals process, to examine the enrollee's case file, including the medical record and any other documents and records considered during the appeals process.
438.406.b.4	GS	7	h	Not Deemed	The MCO must include, as parties to the appeal, the enrollee and his or her representative or the legal representative of a deceased enrollee's estate.
438.408.a	GS	8			The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established time frames.
438.408.b.1	GS	8	a	Not Deemed	The MCO must dispose of each standard grievance and provide notice to the affected parties within 90 days from the day the MCO receives the grievance.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.408.b.2	GS	8	b	Not Deemed	The MCO must resolve each standard appeal and provide notice to the affected parties within 45 days from the day on which the MCO receives the appeal, unless an extension is requested.
438.408.b.3	GS	8	c	Not Deemed	The MCO must resolve expedited appeals and provide notice to the affected parties within three working days after the MCO receives the appeal, unless an extension is requested.
438.408.c.1	GS	8	d	Not Deemed	The MCO may extend the periods for resolving appeals and expedited appeals by up to14 calendar days if the enrollee requests the extension or the MCO shows that there is a need for additional information and that the delay is in the enrollee's interest.
438.408.c.2	GS	8	e	Not Deemed	The MCO must give the enrollee written notice of the reason for a delay due to any extension not requested by the enrollee.
438.408.d	GS	9			The MCO must notify any enrollee who has entered a grievance or appeal of the outcome of his or her case.
438.408.d.1	GS	9	a	Not Deemed	The MCO must comply with the State's regulations regarding the method the MCO will use to notify an enrollee of the disposition of a grievance.
438.408.d.2.i	GS	9	b	Not Deemed	The MCO must provide the enrollee with a written notice of disposition for all appeals.
438.408.d.2.ii	GS	9	c	Not Deemed	The MCO must also make reasonable efforts to provide oral notice to the enrollee for notices of expedited resolution.
438.408.e.1	GS	9	d	Not Deemed	The MCO must provide to the enrollee a written notice of the resolution that includes the results of the resolution process and the date it was completed.
438.408.e.2.i	GS	9	e	Not Deemed	The MCO must provide to the enrollee a written notice of the resolution that describes, for appeals not resolved wholly in favor of the enrollee, the enrollee's right to request a State Fair Hearing and how to do so.
438.408.e.2.ii	GS	9	f	Not Deemed	The MCO must provide to the enrollee a written notice of the resolution that explains the right to request to receive benefits while the State Fair Hearing is pending and how to request such benefits when an appeal is not resolved wholly in favor of the enrollee.

438.408.e.2.iii	GS	9	g	Not Deemed	If the appeal is not resolved wholly in favor of the enrollee at the State Fair Hearing, the MCO must provide to the enrollee written notice that he or she may be held liable for the cost of benefits delivered while the appeal is pending.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.410.b	GS	10	b	Not Deemed	The MCO must ensure that no punitive action is taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
438.410.c.1	GS	10	c	Not Deemed	The MCO must transfer the appeal to the time frame for standard resolution in accordance with 42 CFR § 438.408.b.2 if the MCO denies a request for expedited resolution of an appeal.
438.410.c.2	GS	10	d	Not Deemed	The MCO must make reasonable efforts to give the enrollee prompt oral notice of the denial and follow up within two calendar days with a written notice if the MCO denies a request for expedited resolution of an appeal.
438.414	GS	11			The MCO must provide information about the grievance system to all providers and subcontractors at the time they enter into a contract.
438.410.g.1.ii	GS	11	a	Not Deemed	The MCO must inform providers and subcontractors about the right to file grievances and appeals at the time they enter into a contract.
438.410.g.1.iii	GS	11	b	Not Deemed	The MCO must inform providers and subcontractors about the requirements and time frames for filing a grievance or appeal at the time they enter into a contract.
					The MCO must inform providers and subcontractors about the availability of assistance
438.410.g.1.iv	GS	11	c	Not Deemed	The MCO must inform providers and subcontractors about the availability of assistance in the filing process at the time they enter into a contract.
438.410.g.1.v	GS	11	d	Not Deemed	The MCO must inform providers and subcontractors about the toll-free numbers that the enrollee can use to file a grievance or an appeal by telephone at the time they enter into a contract.
438.416	GS	12		Not Deemed	The MCO must maintain records of grievances and appeals and must review the information as part of the State's quality strategy.
438.420	GS	13			The MCO must continue to provide benefits to the enrollee while the appeal and the State Fair Hearing are pending.
438.420.b.1	GS	13	a	Not Deemed	The MCO must continue the enrollee's benefits pending resolution if the enrollee or the provider files the appeal timely.
438.420.b.2	GS	13	b	Not Deemed	The MCO must continue the enrollee's benefits pending resolution if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

438.420.b.3	GS	13	c	Not Deemed	The MCO must continue the enrollee's benefits pending resolution if the services were ordered by an authorized provider.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.420.b.4	GS	13	d	Not Deemed	The MCO must continue the enrollee's benefits pending resolution if the period covered by the original authorization has not expired.
438.420.b.5	GS	13	e	Not Deemed	The MCO must continue the enrollee's benefits pending resolution if the enrollee requests extension of benefits.
438.420.c.1	GS	13	f	Not Deemed	If the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until the enrollee withdraws the appeal.
438.420.c.2	GS	13	g	Not Deemed	If the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits need not be continued past 10 days after the MCO mails notice of an adverse resolution unless the enrollee has requested continuation of benefits pending a State Fair Hearing decision.
438.420.c.3	GS	13	h	Not Deemed	If the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until a State Fair Hearing officer issues a hearing decision adverse to the enrollee.
438.420.c.4	GS	13	i	Not Deemed	If the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until the time period or service limit of a previously authorized service has been met.
438.420.c.4	GS	13	i	Not Deemed	If the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until the time period or service limit of a previously
438.420.d	GS	14		Not Deemed	The MCO may recover the cost of the services furnished to the enrollee while the appeal is pending if the final resolution of the appeal is adverse to the enrollee, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR § 431.230.b.
438.424.a	GS	15		Not Deemed	The MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, if the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending.

438.424.b	GS	16		Not Deemed	The MCO or the State must pay for those services, in accordance with State policy and regulations, if the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
Subpart D - Quality Assessment and Performance Improvement QA					
438.100.1	QA	1			The MCO must 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.
438.100.1.i	QA	1	a	Not Deemed	In establishing and maintaining the network, the MCO must consider the anticipated Medicaid enrollment.
438.100.1.ii	QA	1	b	Not Deemed	In establishing and maintaining the network, the MCO must consider the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO.
438.100.1.iii	QA	1	c	Not Deemed	In establishing and maintaining the network, the MCO must consider the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
438.100.1.iv	QA	1	d	Not Deemed	In establishing and maintaining the network, the MCO must consider the number of network providers who are not accepting new Medicaid patients.
438.100.1.v	QA	1	e	Not Deemed	In establishing and maintaining the network, the MCO must consider 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	QA	2			Each MCO, consistent with the scope of the contracted services, must meet the following requirements:

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.206.b.2	QA	2	a	Not Deemed	The MCO must 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.3	QA	2	b	Not Deemed	The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.
438.206.b.4	QA	2	c	Not Deemed	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 cannot do so.
438.206.b.5	QA	2	d	Not Deemed	The MCO must coordinate with the out-of-network provider with respect to payment and ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.
438.206.c	QA	3			The MCO must furnish services timely.
438.206.c.1.i	QA	3	a	Deemed	The MCO must meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of need for services.
438.206.c.1.ii	QA	3	b	Not Deemed	The MCO must ensure that the network providers offer hours of operation that are no less than the hours available to commercial enrollees or, if the provider serves only Medicaid enrollees, hours of operation comparable to those available for Medicaid fee-for-service.
438.206.c.1.iii	QA	3	c	Not Deemed	The MCO must make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.206.c.1.iv	QA	3	d	Deemed	The MCO must establish mechanisms to ensure compliance by providers.
438.206.c.1.v	QA	3	e	Deemed	The MCO must monitor providers regularly to determine compliance.
438.206.c.1.vi	QA	3	f	Deemed	The MCO must take corrective action if there is failure to comply.
438.206.c.2	QA	4		Deemed	Each MCO must participate in the State'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.
438.208.b	QA	5			The MCO must implement procedures to deliver primary care to and coordinate health care services for all MCO enrollees. These procedures must meet state requirements and must do the following:
438.208.b.1	QA	5	a	Not Deemed	The MCO must 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.
438.208.b.2	QA	5	b	Not Deemed	The MCO must coordinate the services that enrollees receive from the MCO with the services that the enrollee receives from any other MCO, PIHP, or PAHP.
438.208.b.3	QA	5	c	Not Deemed	The MCO must share with other MCOs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.
438.208.b.4	QA	5	d	Not Deemed	The MCO must ensure that, in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 42 CFR, Parts 160 and 164, Subparts A and E, to the extent that they are applicable.
438.208.c	QA	6			The MCO must coordinate services for enrollees with special health care needs.
438.208.c.1	QA	6	a	Not Deemed	The State must implement mechanisms to identify persons with special health care needs to MCOs as those persons are defined by the State.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.208.c.2	QA	6	b	Not Deemed	The MCO must implement mechanisms to assess each Medicaid enrollee identified by the State and identified to the MCO by the State 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.
438.208.c.2	QA	6	c	Not Deemed	The MCO's assessment mechanisms must use the appropriate health care professionals.
438.208.c.3.i	QA	7			The MCOs must develop a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.
438.208.c.3.i	QA	7	a	Not Deemed	The treatment plan must be developed by the enrollee's primary care provider with enrollee participation.
438.208.c.3.i	QA	7	b	Not Deemed	The treatment plan must be developed in consultation with any specialists caring for the enrollee.
438.208.c.3.ii	QA	7	c	Not Deemed	The treatment plan must be approved by the MCOs in a timely manner, if this approval is required by the MCO.
438.208.c.3.iii	QA	7	d	Not Deemed	The treatment plan must be in accord with any applicable state quality assurance and utilization review standards.
438.208.c.4	QA	8		Not Deemed	The MCO must have a mechanism in place to allow enrollees with special health care needs to directly access a specialist.
438.210.b	QA	9			The MCO must have a written procedure in place for processing requests for initial and continuing authorizations of services.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.210.b.1	QA	9	a	Deemed	The MCO and its subcontractors must have in place and follow written policies and procedures for authorization of initial and continuing services.
438.210.b.2.i	QA	9	b	Deemed	The MCO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
438.210.b.2.ii	QA	9	c	Deemed	The MCO must consult with the requesting provider when appropriate.
438.210.b.3	QA	9	d	Deemed	Any MCO decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's disease.
438.210.c	QA	10		Deemed	The MCO must 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 42 CFR § 438.404, except that the notice to the provider need not be in writing.
438.210.d	QA	11			The MCO must provide timely authorization decisions.
438.210.d.2.i	QA	11	a	Deemed	The MCO must expedite authorization decisions and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service, whenever a provider indicates, or the MCO determines, that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
438.210.d.2.ii	QA	11	b	Not Deemed	The MCO may extend the three-working-day time period by up to 14 calendar days if the enrollee requests an extension or if the MCO justifies to the state agency, upon request, that additional information is needed and that the extension is in the enrollee's interest.
438.210.e	QA	12		Not Deemed	The MCO must not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.114.b	QA	13	438.114.b		The MCO must cover and pay for emergency services and post-stabilization care services.
438.114.c.1.i	QA	13	a	Not Deemed	The MCO must cover and pay for emergency services regardless of whether the entity that furnishes the services has a contract with the MCO.
438.114.c.1.ii.A	QA	13	b	Not Deemed	The MCO may not deny payment for treatment obtained for an enrollee's emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definitions of emergency medical condition in paragraph (a) of this section.
438.114.c.1.ii.B	QA	13	c	Not Deemed	The MCO may not deny payment for treatment obtained if a representative of the MCO instructed the enrollee to seek emergency services.
438.114.d.1.i	QA	13	d	Not Deemed	The MCO may not limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms.
438.114.d.1.ii	QA	13	e	Not Deemed	The MCO may not refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the enrollee's primary care provider, MCO, or applicable state entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.
438.114.d.2	QA	13	f	Not Deemed	The MCO cannot hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition to stabilize the patient.
438.114.d.3	QA	13	g	Not Deemed	The attending emergency physician, or the provider, actually treating the enrollee is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.114.e	QA	13	h	Not Deemed	Post-stabilization care services are to be covered and paid for in accordance with provisions set forth at 42 CFR § 422.113.c of this chapter.
438.214.a	QA	14			The MCO must implement written policies and procedures for selection and retention of providers.
438.214.b.1	QA	14	a	Not Deemed	The MCO must establish a uniform credentialing and recredentialing policy in accordance with state requirements.
438.214.b.2	QA	14	b	Deemed	The MCO must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the MCO.
438.214.c	QA	15			The MCO's provider selection policies and procedures must not discriminate against particular practitioners that serve high-risk populations or specialize in conditions that require costly treatment.
438.12.a.1	QA	15	a	Not Deemed	The MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.
438.12.a.2	QA	15	b	Not Deemed	The MCO must comply with the requirements specified in 42 CFR § 438.214 in all contracts with health care professionals.
438.214.d	QA	15	c	Not Deemed	The MCO may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Balanced Budget Act of 1997.
438.2 14.e	QA	15	d	Not Deemed	The MCO must comply with any additional requirements established by the State. (Note: any state requirements re credentialing will be included here and will be found in the reviewer guidelines.)
438.224	QA	16		Not Deemed	The MCO must ensure through its provider contracts that it discloses individually identifiable health information in accordance with the privacy requirements (HIPAA provisions).
438.56.b	QA	17		Not Applicable	The MCO must comply with the enrollment and disenrollment requirements and limitations set forth in 42 CFR § 438.56.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.56.b.1	QA	17	a	Not Applicable	All MCO contracts must specify the reasons for which the MCO may request disenrollment of an enrollee.
438.56.b.2	QA	17	b	Not Applicable	The MCO must include in its contracts the requirement that the MCO may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish service to either this particular enrollee or other enrollees).
438.56.b.3	QA	17	c	Not Applicable	The MCO must include in its contracts and comply with the requirement that it have specific methods by which it assures that it does not request disenrollment for reasons other than those permitted under the contract.
438.56.c	QA	18			If the State chooses to limit disenrollment, the MCO contracts must provide that a recipient may request disenrollment.
438.56.c.1	QA	18	a	Not Applicable	The MCO must provide that a recipient may request disenrollment for cause, at any time.
438.56.c.2.i	QA	18	b	Not Applicable	The MCO must provide that a recipient may request disenrollment without cause, during the 90 days following the date of the recipient's initial enrollment with the MCO or the date the State sends the recipient notice of the enrollment, whichever is later.
438.56.c.2.ii	QA	18	c	Not Applicable	The MCO must provide that a recipient may request disenrollment without cause, at least once every 12 months after initial enrollment or notice of enrollment.
438.56.c.2.iii	QA	18	d	Not Applicable	The MCO must provide that a recipient may request disenrollment without cause, upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.
438.56.c.2.iv	QA	18	e	Not Applicable	The MCO must provide that a recipient may request disenrollment without cause, when the State imposes the intermediate sanction specified in 42 CFR § 438.702(a)(3).

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.56.d	QA	19			The MCO must maintain procedures for disenrollment.
438.56.d.1.i	QA	19	a	Not Applicable	The MCO's disenrollment procedures must cover circumstances in which the enrollee or his or her representative submits an oral or written request for disenrollment directly to the state agency.
438.56.d.1.ii	QA	19	b	Not Applicable	The MCO's disenrollment procedures must cover circumstances in which the recipient or his or her representative submits an oral or written request for disenrollment to the MCO, if the State permits MCOs to process disenrollment requests.
438.56.d.2.i	QA	19	c	Not Applicable	The MCO's disenrollment procedures must cover circumstances in which the enrollee moves out of the MCO service area.
438.56.d.2.ii	QA	19	d	Not Applicable	The MCO's disenrollment procedures must cover circumstances in which the MCO does not, because of moral or religious objections, offer the service the enrollee seeks.
438.56.d.2.iii	QA	19	e	Not Applicable	The MCO's disenrollment procedures must cover circumstances in which the enrollee needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
438.56.d.2.iv	QA	19	f	Not Applicable	The MCO's disenrollment procedures must cover other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.
438.56.d.5	QA	20			The MCO must maintain grievance procedures.
438.56.d.5.i	QA	20	a	Not Applicable	The MCO's grievance procedures must provide that the state agency may require that the enrollee seek redress through the MCO grievance system before making a determination on the enrollee's request.
438.56.d.5.ii	QA	20	b	Not Applicable	The MCO's grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the time frame specified in 42 CFR § 438.56.e.1.

438.56.d.5.iii	QA	20	c	Not Applicable	The MCO's grievance process must stipulate that if, as a result of the grievance process, the MCO approves the disenrollment, the state agency is not required to make a determination.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.56.e	QA	21			The MCO must provide for timely disenrollment.
438.56.e.1	QA	21	a	Not Applicable	The MCO must assure that the effective date of an approved disenrollment be no later than the first day of the second month following the month in which the enrollee or the MCO files the request.
438.56.e.2	QA	21	b	Not Applicable	If the MCO or the state agency fails to make the determination within the time frames specified in 42 CFR § 438.56.e.1, the disenrollment is considered approved.
438.228	QA	22			The MCO must maintain grievance systems.
438.228.a	QA	22	a	Not Deemed	The MCO's state contract must ensure that the MCO has in effect a grievance system that meets the requirements of 42 CFR Subpart F.
438.228.b	QA	22	b	Not Deemed	If the State delegates to the MCO responsibility for notice of action under Subpart E of Part 431, the State must conduct random reviews of each delegated MCO and its providers and subcontractors to ensure that they are notifying enrollees in a timely
438.230.a.1-2	QA	23			The MCO must oversee and is accountable for any functions and responsibilities that it delegates to any subcontractor. The following conditions must be met:
438.230.b.1	QA	23	a	Deemed	The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated before any delegation is undertaken.
438.230.b.2.i	QA	23	b	Deemed	The MCO must maintain a written agreement that specifies the activities and report responsibilities designated to the subcontractor.
438.230.b.2.ii	QA	23	c	Deemed	The MCO must maintain a written agreement that provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
438.230.b.3	QA	23	d	Deemed	The MCO must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or the State's MCO laws and regulations.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.230.b.4	QA	23	e	Deemed	If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor must take corrective action.
438.236.a	QA	24			The MCO must maintain practice guidelines. The adopted practice guidelines must address the following requirements:
438.236.b.1	QA	24	a	Deemed	The MCO's adopted practice guidelines must be based on valid and reliable clinical evidence or a consensus of health care professionals in the field.
438.236.b.2	QA	24	b	Deemed	The MCO's adopted practice guidelines must consider the needs of the MCO's enrollees.
438.236.b.3	QA	24	c	Deemed	The MCO's practice guidelines must be adopted in consultation with contracting health care professionals.
438.236.b.4	QA	24	d	Deemed	The MCO's practice guidelines must be reviewed and updated periodically, as appropriate.
438.236.c	QA	24	e	Deemed	The MCO must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
438.236.d	QA	24	f	Deemed	The MCO must apply the practice guidelines when making decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.
438.240.b.1	QA	25			The MCO must conduct performance improvement projects that achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas of clinical and non-clinical care and are expected to have a favorable effect on health outcomes and enrollee satisfaction.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.240.d.1.i	QA	25	a	Not Deemed, But Included in PIPs	The performance improvement projects must measure performance using objective quality indicators.
438.240.d.1.ii	QA	25	b	Not Deemed, But Included in PIPs	The performance improvement projects must implement system interventions to achieve improvement in quality.
438.240.d.1.iii	QA	25	c	Not Deemed, But Included in PIPs	The performance improvement projects must evaluate the effectiveness of the intervention.
438.240.d.1.iv	QA	25	d	Not Deemed, But Included in PIPs	The performance improvement projects must plan and initiate activities for increasing or sustaining improvement.
438.240.d.2	QA	25	e	Not Deemed, But Included in PIPs	The MCO must report the status and results of each project to the State as requested.
438.240.d.2	QA	25	f	Not Deemed, But Included in PIPs	Each of the MCO's performance improvement projects must be completed in a reasonable time period so as to allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
438.240.b.2	QA	26			The MCO must submit performance measurement data.
438.240.c.1	QA	26	a	Not Deemed But Included in PMV	The MCO must annually measure and report to the State its performance, using standard measures required by the State.

Contract/ CFR Reference	CFR Standard	Element	Component	Deeming Status	Element/Component Description
438.240.c.2	QA	26	b	Not Deemed Included in PMV	The MCO must annually submit to the State data specified by the State that enables the State to measure the MCO's performance.
438.240.b.3	QA	27		Not Deemed	The MCO must have in effect mechanisms to detect both under- and over-utilization of services.
438.240.b.4	QA	28		Not Deemed	The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
	QA	29			The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances, and disenrollments for other than loss of Medicaid eligibility.
		29	a	Not Deemed But Included in PMV	The MCO's health information system must collect data on enrollee and provider characteristics as specified by the State and on services furnished to enrollees an encounter data system or such other methods as may be specified by the State.
	QA	29	b	Not Deemed But Included in PMV	The MCO's health information system must ensure that data received from providers are accurate and complete by verifying the accuracy and timeliness of reported data.
	QA	29	c	Not Deemed But Included in PMV	The MCO's health information system must ensure that data received from providers are accurate and complete by screening the data for completeness, logic, and consistency.
	QA	29	d	Not Deemed But Included in PMV	The MCO's health information system must ensure that data received from providers are accurate and complete by collecting service information in standardized formats to the extent feasible and appropriate.
	QA	29	e	Not Deemed but in PMV	The MCO must make all collected data available to the State and upon request to CMS.

PIP Validation Worksheet

MCO Name	
Title of Study	
Project Leader	
Telephone	
Email	
Study Period	
Reporting Cycle	

Validation Scoring:

M=Met
P=Partially Met
N=Not Met
NA=Not Applicable

Component/Standard	M	P	N	NA	Comments
STEP 1: REVIEW THE SELECTED STUDY TOPIC(S)					
1.1 Was the topic selected through data collection and analysis of comprehensive aspect of enrollee needs, care and services?					
1.2 Did the MCO's PIPs over time address a broad spectrum of key aspects of enrollee care and services?					
1.3 Did the MCO's PIPs over time include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?					
Step 1 Assessment					
STEP 2: REVIEW THE STUDY QUESTION(S)					
2.1 Was/were the study question(s) stated in clear and simple terms?					
2.2 Was/were the study question(s) answerable/provable?					
Step 2 Assessment					
STEP 3: REVIEW THE SELECTED STUDY INDICATOR(S)					
3.1 Did the study use objective, clearly defined, and measurable indicators?					
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?					
Step 3 Assessment					
STEP 4: REVIEW THE IDENTIFIED STUDY POPULATION					
4.1 Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators are relevant?					
4.2 If the MCO studied the entire population, did its data collection approach capture all enrollees to whom the study questions applied?					
Step 4 Assessment					
STEP 5: REVIEW SAMPLING METHODS					

5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?					
5.2 Did the MCO employ valid sampling techniques that protected against bias? Specify the type of sampling or census used.					
5.3 Did the sample contain a sufficient number of enrollees?					
Step 5 Assessment					
STEP 6: REVIEW DATA COLLECTION PROCEDURES					
6.1 Did the study design clearly specify the data to be collected?					
6.2 Did the study design clearly specify the sources of data?					
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?					
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?					
6.5 Did the study design prospectively specify a data analysis plan?					
6.6 Were qualified staff and personnel used to collect the data?					
Step 6 Assessment					
STEP 7: ASSESS IMPROVEMENT STRATEGIES					
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?					
Step 7 Assessment					
STEP 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS					
8.1 Was an analysis of the findings performed according to the data analysis plan?					
8.2 Did the MCO present numerical PIP results and findings accurately and clearly?					
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?					
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?					
Step 8 Assessment					
STEP 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT					
9.1 Was the same methodology as the baseline measurement used, when					

measurement was repeated?					
9.2 Was there any documented quantitative improvement in processes or outcomes of care?					
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?					
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?					
Step 9 Assessment					
STEP 10: ASSESS SUSTAINED IMPROVEMENT					
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?					
Step 10 Assessment					

Performance Improvement Project Validation Summary				
Findings for: ☐ Proposal ☐ Remeasurement ☐ Final ☐ Resubmission				
Strengths:				
Significant Barriers/Issues Experienced by MCO:				
Best/Most Notable Interventions:				
Results:				
Comments/Recommendations:				
PIP Validation Scoring				
Validation Step	Met	Partially Met	Not Met	Not Applicable
Study Topic and Project Rationale	☐	☐	☐	☐
Study Question	☐	☐	☐	☐
Study Indicators	☐	☐	☐	☐
Study Population	☐	☐	☐	☐

Sampling	☐	☐	☐	☐
Methodology	☐	☐	☐	☐
Interventions	☐	☐	☐	☐
Data Analysis	☐	☐	☐	☐
Assessment of *Real* Improvement	☐	☐	☐	☐
Sustained Improvement	☐	☐	☐	☐
Final Assessment				
☐ PIP meets requirements				
☐ PIP meets requirements with recommendations				
☐ PIP requires revisions; resubmission required				
☐ PIP does not meet requirements				
☐ Other:				

APPENDIX F

Improving Childhood Immunization Rates
A Case Study

The State of Childhood Immunizations in Virginia

Virginia's immunization rates indicate that the vast majority of children with Medicaid or CHIP are receiving the right vaccines at the right time. Timely immunizations are important to both the individuals receiving them and to health of the surrounding communities.

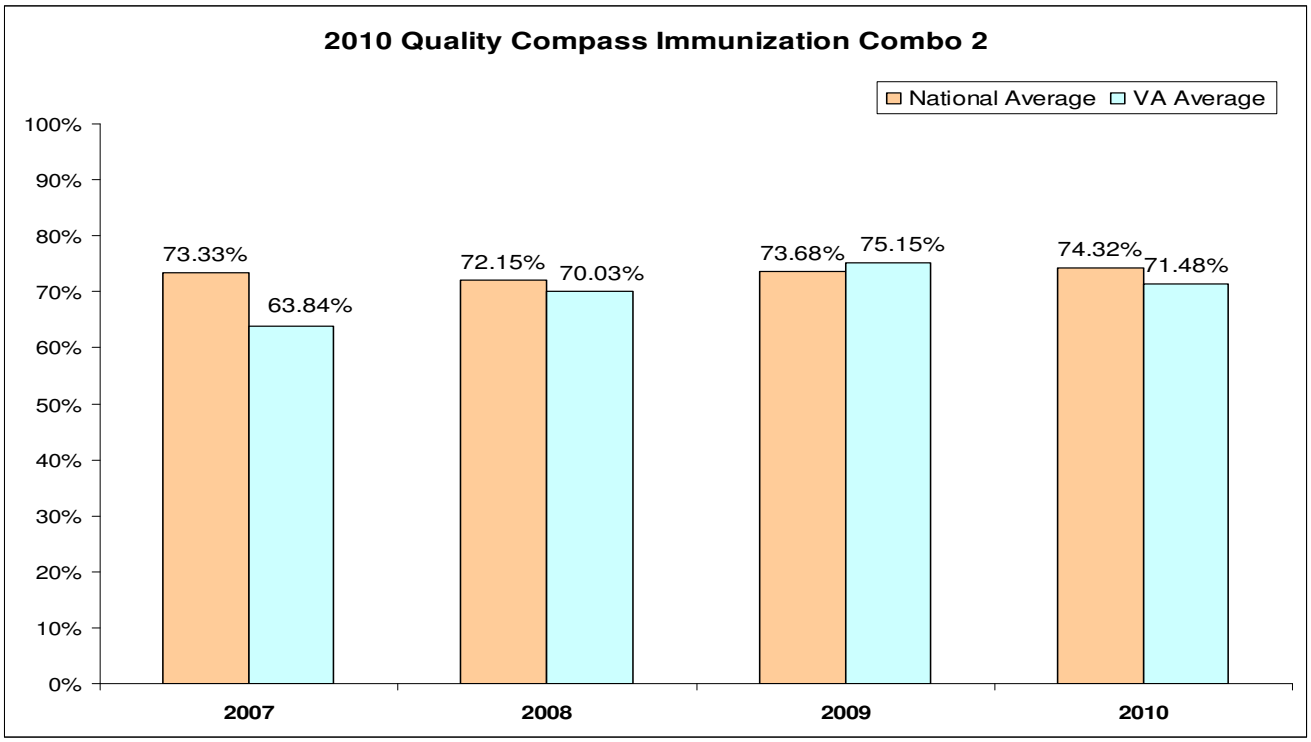
The Centers for Disease Control and Prevention emphasizes the importance of timely immunizations "Recommendations for the age at which vaccines are administered are influenced by age-specific risks for disease, age-specific risks for complications, ability of persons of a certain age to respond to the vaccine, and potential interference with the immune response by passively transferred maternal antibody. Vaccines are recommended for members of the youngest age group at risk for experiencing the disease for which efficacy and safeties have been demonstrated."

Virginia is uniquely positioned in that it requires all of its Medicaid managed care organizations (MCOs) to be accredited by the National Committee for Quality Assurance (NCQA). Each year, all of the accredited MCOs are required by NCQA to report on their healthcare effectiveness data and information set (HEDIS), which includes measures for immunizations. The HEDIS requirements for immunizations are very close to the requirements set forth each year by the CDC's Advisory Committee on Immunization Practice. DMAS is dedicated to ensuring that children are receiving the right vaccines at the right time, and as such, has adopted the immunization HEDIS measures as a performance measure for its MCOs.

School health policies which require all children entering school to be fully immunized also impact immunization rates. This requirement for school entry is effective for "catch up immunizations" however; it is not one that predisposes children to have the right vaccines at the right time, when they are most effective for preventing disease.

DMAS and the MCOs recognize that measuring immunization rates based on the standard of care/recognized clinical guidelines is much more effective for protecting the health of communities. HEDIS measures for immunizations are more aligned with nationally recognized clinical guidelines than the immunization measure based on immunization status upon school entry. Even though a number of states may reference immunization rates upon entry to school as their statewide rate, Virginia aims for continuously improving HEDIS immunization rates.

The following diagram demonstrates the improvement in HEDIS childhood immunization rates for Virginia in comparison to the national average. The national average improved only 1% from '06 to '10, compared to Virginia's improvement of nearly 8% for the same timeframe.



% Children who, by age 2, received DTaP, IPV, MMR, Hib, Hep B, & VZV

Specific initiatives that DMAS is engaged in for increasing childhood immunization rates include:

- Representation on Project Immunize Virginia, a statewide coalition dedicated to increasing immunization rates across the lifespan.
- DMAS and the MCOs have established a partnership with the Virginia Immunization Registry. The MCOs are able to access the Registry data and use it as one source of administrative data for calculating HEDIS scores. Additionally, the MCOs are able to provide data-feeds into the registry. Virginia is not a state that requires providers to enter immunizations into the registry.
- Quality improvement activities with the Medicaid/CHIP managed care organizations include:
    - Annual performance improvement projects (PIPs) must include childhood immunizations and are validated by the (EQRO) every year.
    - The quarterly MCO collaborative meeting, which is facilitated by DMAS, has included open dialogue with the Virginia Department of Health's Vaccines for Children Program. The discussion led to a helpful question and answer document on the VFC program and on Medicaid/CHIP coverage of vaccines.

DMAS continues to work collaboratively with key stakeholders to identify best practices, opportunities for improvement, and solutions to barriers in an effort to increase immunization rates. The intent is to increase the administration of the right vaccines, at the right time, to the right children.

Appendix G

Letter from Centers for Medicare & Medicaid Services Approval of Virginia's Medicaid/CHIP Managed Care Quality Strategy

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

To: Carol Stanley
From: Gary Jackson
Re: Approval of Virginia 2011-2015 Quality Strategy
Date: May 19, 2011

Dear Ms Stanley,

CMS has reviewed the second edition of the Virginia 2011 Managed Care Quality Strategy and it is approved as drafted to be effective after your second public posting. The Quality Strategy meets all federal requirements and demonstrates your Commonwealth's commitment to the quality of health care received by your Medicaid and CHIP beneficiaries. It will be a useful tool for you in administering your Medicaid and CHIP programs in the future.

Sincerely,

Gary B. Jackson