# State of Alaska
# Medicaid Managed Care Quality Strategy

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## *Section 1: INTRODUCTION*

### Program Background

Since its inception, the Alaska (AK) Medicaid program has operated a fee-for-service (FFS) reimbursement model, emphasizing the volume of services rather than value of services being provided. However, through Senate Bill 74, the 2016 AK Legislature directed the Department of Health and Social Services (DHSS) to implement a series of multiple specific demonstration projects – collectively known as the Coordinated Care Demonstration Projects (CCDP) – to test the efficacy of new models of care in Alaska. Under the overarching goal of improving the health and well-being of Alaskans, the intent of the CCDP is the coordinating and integrating of services, improving quality of care, and achieving cost-savings through value based care. As a result of the solicitation process, the State chose to move forward with implementation of a managed care program limited in scope to two (2) populous geographic regions within the State.

Through a 1915(a) statutory authority, the State developed a model managed care contract per the Centers for Medicare and Medicaid Services (CMS) guidelines and intends to go live with the program in 2019.

### Managed Care Goals & Objectives (42 CFR 438.340(b)(2))

The Alaska Medicaid Managed Care Quality Strategy is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to all populations in the managed care program. The Quality Strategy provides a framework for the State to communicate the vision, objectives, and monitoring strategies for attaining improved quality of care, timely access to care, and cost effectiveness.

Managed Care Program Goals:

- Improve access to care – Measured through network adequacy reports, and case management reports.
- Improved quality of care – Measured through utilization data analysis and self-reporting (CAHPS Survey, patient satisfaction surveys).
- Cost effectiveness – Measured through encounter data analysis and value based purchasing (VBP) reporting.

### Development & Review of Quality Strategy

Throughout the development of the Quality Strategy, the 42 Code of Federal Regulations (CFR) Part 438 was utilized to ensure compliance with the rules governing Medicaid Managed Care, including the Final Rule for Medicaid Managed Care, as published by CMS on May 6, 2016.

Prior to adopting it as final, the Quality Strategy will be made available for public comment and placed on the State's website, indicating a 30-day period for public input. Suggested revisions to the proposed Quality Strategy and improvement goals will be considered as appropriate prior to submission of the final document to CMS. Following approval, any amendments to the Quality Strategy will be shared with CMS. The final Quality Strategy will also be published on the State's website and will be available for ongoing public review and comment.

The Quality Strategy will be reviewed at least annually by the Division of Health Care Services (DHCS) leadership team. Throughout the review process strategic partnerships among stakeholders may be established to obtain input on the State's quality assessment and improvement strategies. Input may be incorporated into the Quality Strategy from the External Quality Review Organization (EQRO), partner government agencies, providers, Members, and advocates; all providing information useful in identifying quality activities. Following the review process, the leadership team shall present recommendations with regard to whether or not revisions to the Quality Strategy may be required; specifying any revisions identified, to the Medical Care Advisory Committee.

The Division of Health Care Services has the overall responsibility for the quality oversight process that governs all managed care Members. The leadership team serves as the unifying point by tracking trends and reporting information from MCO and providing recommendations for improvement and corrective action.

**Ongoing monitoring**

The DHCS program managers will monitor MCO compliance through ongoing desk reviews of policies and procedures, including grievances, fraud and abuse, credentialing, claims payment and encounter reporting. Staff assess enrollee materials for content and reading level, communication of enrollee rights and responsibilities, and compliance with privacy and confidentiality policies.

Contractually required reports will be tied to an "owner" within DHCS who will assume responsibility for the ongoing analysis of requisite documents, which allows for more efficient and precise compliance monitoring by subject matter experts (SME). Should issues or deficiencies be discovered during the course of the SME's review, the MCO is required to correct identified deficiencies with DHCS tracking corrective actions to ensure compliance.

**Annual review**

DHCS conducts contract monitoring compliance through two separate mechanisms. The DHCS contracts with an EQRO to conduct annual monitoring activities, as well as using agency staff. The monitoring review process uses DHCS-defined standards and guidelines to assess MCO compliance with regulatory requirements and standards for the quality outcomes, timeliness of care, and access to services provided by the MCO contractor. Additional standards and monitoring guidelines such as those promulgated by the National Committee for Quality Assurance (NCQA) may also be used. When necessary, DHCS imposes corrective actions and appropriate sanctions for standards not in compliance.

**Definition of "Significant Change" (42 CFR 438.380(b)(11))**
For the Alaska Medicaid Program, significant change is defined as a change to the managed care population or within State or federal regulations that necessitates a modification in Alaska managed care policies, benefits, or quality improvement processes and activities, carried out within DHSS.

**Non-Duplication of External Quality Review Activities (42 CFR 438.360(c))**
The Final Rule requires this report to include information required under 42 CFR 438.360(c), relating to non-duplication of EQRO activities and Medicare coordination. DHSS does not have any information to report under this section.

## *Section II: ASSESSMENT*

**Quality and Appropriateness of Care**
The State will assess how well the MCO program is meeting the objectives outlined in the Section I through analysis of the quality and appropriateness of care for services delivered to Members, including those with special health care needs, and the level of contract compliance of the MCO.

The State assesses the quality and appropriateness of care delivered to Medicaid managed care Members through:

- Internal monitoring
- Quality Reporting (Attachment 4 of contract)
- Performance Improvement Projects (PIPs)
- EQRO activities and an annual EQRO Report

**Long-Term Services and Supports (LTSS) and Special Health Care Needs (42 CFR 438.208(c)(1))**
Members with special health care needs are those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by Members, generally. The MCO shall ensure there is access and care coordination to all services to meet the health needs of Members with special health care needs in accordance with the covered services, limitations, and exclusions. The Final Rule requires this report to include the mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1), relating to the identification of persons who need long-term services and supports or persons with special health care needs.

Within ninety (90) calendar days of enrollment, the MCO shall identify individuals with special health care needs in accordance with section 13.2 of the model contract, which includes the resources that may be utilized to identify individuals with special healthcare needs as well as required quarterly reports (42 CFR 438.208).

The MCO must also ensure continuity of care for Members in an active course of treatment for chronic conditions, as well as guaranteeing that medically necessary care for Members is not interrupted and that transitions from one setting or level of care to another are promoted (42 CFR 438.208). The MCO will formally designate a person or entity as primarily responsible for coordinating services accessed by the Member. If possible and reasonable, the MCO must make every effort to preserve Member provider relationships through transitions of care. Where preservation of provider relationships is not possible and reasonable, the MCO will provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the Member's medical condition requires.

The managed care plan will not provide LTSS services to beneficiaries, as these services will remain covered under FFS.

**Identify Race, Age, Sex, Ethnicity, Disability Status, and Primary Language (42 CFR 438.340(b)(6))**

Information about the race, age, sex, ethnicity, disability status and primary language of Members is collected by eligibility workers at Public Assistance offices and the medical facility staff during the enrollment process. This information is self-reported by the individual and optional on the application and redetermination form. As provided by the individual, State staff enter the information into the eligibility system along with the individual's other Medicaid enrollment application information.

The MCO shall ensure that translation services are provided for written marketing and Member education materials for the top five (5) languages spoken by individuals with limited English proficiency in Alaska, as applicable. The State requires that the MCO and any contractors have oral interpretive services for those who speak any non-English language.

**Alaska Medicaid Quality Indicators**

The Division of Health Care Services has identified the initial measure set to include selective CMS Adult Quality Indicators and Children's Core Set Quality Indicators in addition to specific measures developed by the Alaska Quality and Cost Effectiveness Workgroup comprised of stakeholders from the local community and State staff (Attachment 4). The measures are a selection of the latest standardized and validated measures from recognized and credible organizations, including CMS, the Agency for Healthcare Research and Quality (AHRQ), the HEDIS®, and Consumer Assessment of Healthcare Providers and Systems - CAHPS® Health Plan Survey. Identified measures and performance outcomes shall be published annually on the Alaska Medicaid website (42 CFR 438.10(c)(3)).

The State acknowledges that Attachment 4 may require modification based on the analysis of the identified quality measures as compared to the actual managed care population utilization and trending data. Analysis of the comparative data allows the leadership team to consider and implement the appropriate quality measure to drive quality improvement for Medicaid beneficiaries.

No later than June 15th of each year, quality measures shall be submitted electronically to DHSS utilizing a secure file transfer system. The first contract year reporting shall include all measures noted in the tables below and shall serve as a baseline for subsequent contract years. After the first reporting year the DHCS and MCO shall agree upon measures for the following reporting year.

### Medicaid Performance Measures

The MCO shall report yearly on selected CMS adult and child quality measures, and Alaska Medicaid Quality and Cost Effectiveness Measures.

### 2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

| NQF # | Measure Steward | Measure Name |
|---|---|---|
| **Primary Care Access and Preventive Care** | | |
| 0024 | NCQA | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH) |
| 0033 | NCQA | Chlamydia Screening in Women Ages 16–20 (CHL-CH) |
| 0038 | NCQA | Childhood Immunization Status (CIS-CH) |
| 0418/0418e | CMS | Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH) |
| 1392 | NCQA | Well-Child Visits in the First 15 Months of Life (W15-CH) |
| 1407 | NCQA | Immunizations for Adolescents (IMA-CH) |
| 1448* | OHSU | Developmental Screening in the First Three Years of Life (DEV-CH) |
| 1516 | NCQA | Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH) |
| NA | NCQA | Adolescent Well-Care Visits (AWC-CH) |
| NA | NCQA | Children and Adolescents' Access to Primary Care Practitioners (CAP-CH) |
| **Maternal and Perinatal Health** | | |
| 0139 | CDC | Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH) |
| 0471 | TJC | PC-02: Cesarean Birth (PC02-CH) |
| 1360 | CDC | Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH) |
| 1382 | CDC | Live Births Weighing Less Than 2,500 Grams (LBW-CH) |

| | | |
|---|---|---|
| 1517* | NCQA | Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH) |
| 2902 | OPA | Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH) |
| 2903/2904 | OPA | Contraceptive Care – All Women Ages 15–20 (CCW-CH) |
| **Care of Acute and Chronic Conditions** | | |
| 1800 | NCQA | Asthma Medication Ratio: Ages 5–18 (AMR-CH) |
| NA | NCQA | Ambulatory Care: Emergency Department (ED) Visits (AMB-CH) |
| **Dental and Oral Health Services** | | |
| 2508* | DQA (ADA) | Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH) |
| NA | CMS | Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH) |
| **Experience of Care** | | |
| NA | NCQA | Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) |

## 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

| NQF # | Measure Steward | Measure Name |
|---|---|---|
| **Primary Care Access and Preventive Care** | | |
| 0032 | NCQA | Cervical Cancer Screening (CCS-AD) |
| 0033 | NCQA | Chlamydia Screening in Women Ages 21–24 (CHL-AD) |
| 0039 | NCQA | Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD) |
| 0418/0418e | CMS | Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD) |
| 2372 | NCQA | Breast Cancer Screening (BCS-AD) |
| NA | NCQA | Adult Body Mass Index Assessment (ABA-AD) |
| **Maternal and Perinatal Health** | | |
| 0469/0469e | TJC | PC-01: Elective Delivery (PC01-AD) |
| 1517* | NCQA | Prenatal and Postpartum Care: Postpartum Care (PPC-AD) |
| 2902 | OPA | Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD) |
| 2903/2904 | OPA | Contraceptive Care – All Women Ages 21–44 (CCW-AD) |
| **Care of Acute and Chronic Conditions** | | |
| 0018 | NCQA | Controlling High Blood Pressure (CBP-AD) |
| 0057 | NCQA | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD) |
| 0059 | NCQA | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) |
| 0272 | AHRQ | PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) |
| 0275 | AHRQ | PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) |
| 0277 | AHRQ | PQI 08: Heart Failure Admission Rate (PQI08-AD) |
| 0283 | AHRQ | PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) |
| 1768 | NCQA | Plan All-Cause Readmissions (PCR-AD) |
| 1800 | NCQA | Asthma Medication Ratio: Ages 19–64 (AMR-AD) |
| 2082 | HRSA | HIV Viral Load Suppression (HVL-AD) |
| 2371* | NCQA | Annual Monitoring for Patients on Persistent Medications (MPM-AD) |
| **Behavioral Health Care** | | |
| 0027 | NCQA | Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) |

| Experience of Care | | |
|---|---|---|
| NA*** | NCQA | Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD) |

## *Alaska Medicaid Redesign Quality and Cost Effectiveness Targets*

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
**ACCESS | A.2 Ability to Get Appointment With Provider As Needed**

| NUMBER | MEASURE | COHORT | 2016 BASELINE | 2017 PERFORMANCE | 2021 FIVE YEAR GOAL |
|---|---|---|---|---|---|
| A.2 | Ability to Get an Appointment for Care As Needed | Age 0-21 yrs | 67.2% | 71.0% | 73.9% |
| | | Age 21+ yrs | 60.6% | 68.7% | 66.7% |

**Description**: Adult's perception of whether they were able to get an appointment as quickly as the adult felt was necessary. Parent's perception of whether they were able to get an appointment for their child as quickly as the parent felt was necessary.
**Measure Origin**: National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
**Data Source**: Annual CAHPS Survey.
**Comparable HEDIS Measure**: No

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
**CHRONIC HEALTH | CH.1 Emergency Department Utilization**

| NUMBER | MEASURE | COHORT | 2016 BASELINE | 2017 PERFORMANCE | 2021 FIVE YEAR GOAL |
|---|---|---|---|---|---|
| CH.1 | Emergency Department Utilization (visits per 1,000) | All program enrollees | 637.2 | 727.3 | 573.5 |

**Description**: The number of emergency Department visits per 1,000 Medicaid enrollees.
**Measure Origin**: Quality and Cost Effectiveness Targets Stakeholder Workgroup.
**Data Source**: Medicaid claims data.
**Comparable HEDIS Measure**: No

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
**COST | C.1 Medicaid Spending Per Enrollee**

| NUMBER | MEASURE | COHORT | 2016 BASELINE | 2017 PERFORMANCE | 2021 FIVE YEAR GOAL |
|---|---|---|---|---|---|
| C.1 | Medicaid spending per enrollee | Age 0-21 yrs | $5,828 | $6,761 | $5,245 |
| | | Age 21+ yrs | $10,436 | $12,283 | $9,392 |

**Description**: Consistent with information currently provided, the Department will produce per member and aggregate costs for non-waiver services by service category. Aggregate annual spending per enrollee will be used to measure performance.
**Measure Origin**: Quality and Cost Effectiveness Targets Stakeholder Workgroup.
**Data Source**: DHSS Annual Report: MMIS Medicaid Claim Activity, January 24, 2018
**Comparable HEDIS Measure**: No

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
**COST | C.2 Number of Hospitalizations for Chronic Obstructive Pulmonary Disease (COPD)**

| NUMBER | MEASURE | COHORT | 2016 BASELINE | 2017 PERFORMANCE | 2021 FIVE YEAR GOAL |
|---|---|---|---|---|---|
| C.2 | Number of hospitalizations for Chronic Obstructive Pulmonary Disease | Age 40-64 yrs | 43.8 | 35.9 | 39.4 |
| | | Age 65+ yrs | 69.8 | 57.9 | 62.8 |

**Description**: Per 100,000 enrollee months, number of hospitalizations due to COPD during the reporting period
**Measure Origin**: CMS: Core Set of Adult Health Care Quality Measures for Medicaid.
**Data Source**: Medicaid claims data.
**Comparable HEDIS Measure**: No
**Note**: Hospitalizations attributed to COPD as a first, second or third diagnoses are included in the measure.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
**COST | C.3 Number of Hospitalizations Attributed to a Diabetic Condition**

| NUMBER | MEASURE | COHORT | 2016 BASELINE | 2017 PERFORMANCE | 2021 FIVE YEAR GOAL |
|---|---|---|---|---|---|
| C.3 | Number of hospitalizations attributed to a diabetic condition | Age 18-64 yrs | 22.1 | 20.2 | 19.9 |
| | | Age 65+ yrs | 21.9 | 13.7 | 19.7 |

**Description**: Per 100,000 enrollee months, number of hospitalizations due to a diabetic condition during reporting period.
**Measure Origin**: Quality and Cost Effectiveness Targets Stakeholder Workgroup.
**Data Source**: Medicaid claims data.
**Comparable HEDIS Measure**: No
**Note**: Hospitalizations attributed to diabetes as a first, second or third diagnoses are included in the measure.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure

**COST | C.4 Number of Hospitalizations Attributed to Congestive Heart Failure**

| NUMBER | MEASURE | COHORT | 2016 BASELINE | 2017 PERFORMANCE | 2021 FIVE YEAR GOAL |
|---|---|---|---|---|---|
| C.4 | Number of hospitalizations due to Congestive Heart Failure | Age 18-64 yrs | 14.4 | 15.2 | 13.0 |
| | | Age 65+ yrs | 58.9 | 54.8 | 53.0 |

**Description**: Per 100,000 enrollee months, number of hospitalizations due to Congestive Heart Failure during reporting period.
**Measure Origin**: Modified CMS: Core Set of Adult Health Care Quality Measures for Medicaid.
**Data Source**: Medicaid claims data.
**Comparable HEDIS Measure**: No
**Note**: Hospitalizations attributed to congestive heart failure as a first, second or third diagnoses are included in the measure.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure

**MATERNAL HEALTH | M.3 Prenatal Care During First Trimester**

| NUMBER | MEASURE | COHORT | 2016 BASELINE | 2017 PERFORMANCE | 2021 FIVE YEAR GOAL |
|---|---|---|---|---|---|
| M.3 | Prenatal Care During First Trimester | All live births within program | 77.9% | 80.6% | 85.7% |

**Description**: Percentage of newborns whose mothers had a prenatal visit during first trimester.
**Measure Origin**: CMS: Core Set of Children's Health Care Quality Measures for Medicaid/CHIP
**Data Source**: Medicaid claims data.
**Comparable HEDIS Measure**: Yes. https://www.ncqa.org/hedis/measures/
**Note**: Calculated results may be lower than actuals due to differences in the codes providers use to identify these services.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure

**MATERNAL HEALTH | M.2 Postpartum Care**

| NUMBER | MEASURE | COHORT | 2016 BASELINE | 2017 PERFORMANCE | 2021 FIVE YEAR GOAL |
|---|---|---|---|---|---|
| M.2 | Follow-up after delivery | All live births within program | 38.8% | 40.5% | 42.7% |
| **Description**: Percentage of women who had live births during the reporting year that also had a postpartum visit on or between 21 and 56 days after delivery.<br>**Measure Origin**: CMS: Core Set of Adult Health Care Quality Measures for Medicaid.<br>**Data Source**: Medicaid claims data.<br>**Comparable HEDIS Measure**: Yes. https://www.ncqa.org/hedis/measures/<br>**Note**: Calculated results may be lower than actuals due to differences in the codes providers use to identify these services. | | | | | |

### Alaska Medicaid Internal Monitoring & Contract Compliance

The success of the Quality Strategy requires contract compliance with the standards of 42 CFR 438 Subpart D (access, structure and operations, and measurement and improvement standards). The State will monitor contract compliance of the Quality Strategy through routine reporting requirements, regular meetings with entities, and ongoing communications as appropriate and necessary. To ensure that the Quality Strategy continues to embody the vision and values of the State, the Quality Strategy will undergo reviews and updates as appropriate. The implementation and compliance standards of the Quality Strategy will be measured, monitored, and evaluated by internal reviewers and the EQRO.

### MCO Reporting Requirements

To assist with monitoring, the MCO has contractual reporting requirements with the State to allow for improved oversight and trending over time. The timeframe for reports due to the State include monthly, quarterly, biannually, annually, and occasionally upon request. Exceptions to this schedule will be identified in the model contract.

Reports should be submitted electronically in a format approved by the State. In the event that a report requires revisions or format changes, the State shall provide written notice of such request to the MCO.

### External Quality Review (42 CFR 438.340(b)(4))

The State will contract with an EQRO to perform, on an annual basis, an external, independent review of quality outcomes, timeliness of care, and access to services provided to managed care Members. In addition to the required EQRO activities, the State will select optional activities for the EQRO to perform.

The EQRO must meet the competency and independency requirements detailed in 42 CFR 438.354, and possess staff with demonstrated experience and knowledge of the Medicaid program, managed care delivery systems, quality management methods, research design and

statistical analysis, as well as the resources to conduct needed activities and other skills necessary to carry out activities or supervise any subcontractors.

For the EQR activities conducted, the State's EQRO will submit an annual detailed technical report that describes data aggregation and analysis and the conclusions that were drawn regarding the quality, timeliness, and access to the care furnished by the MCO adherent to the CMS protocols found in 42 CFR 438.364 for External Quality Review (EQR) reports. Included in the annual report will be an executive summary of the MCO's plan performance, including a summary of the MCO's strengths and weaknesses. The EQR report will provide detailed information regarding the regulatory compliance of the Medicaid Expansion program as well as results of PIPs and performance measures (PMs).

The State will use the annual report to determine whether to apply sanctions or take other corrective action as designated in the MCO contract to evaluate existing program goals and inform new program goal development. The State will also use the report to inform the MCO of any needed contract amendments, or revisions to the Quality Strategy. The executive summary and full report will be made available on the Alaska Medicaid website.

## *Section III: STATE STANDARDS*

### NETWORK ADEQUACY AND AVAILABILITY OF SERVICES (42 CFR 438.380(b)(1))

**Access Standard**

**Availability of services (42 CFR 438.206)**

Availability of services ensures that services covered under contracts are available and accessible, in a culturally competent manner, to Members and address geographic, organizational, and equal access. The MCO must ensure that coverage is available to Members on a twenty-four (24) hours a day, seven (7) days a week basis. The MCO must ensure that network providers offer hours of operation that are no less than those offered to commercial Members.

The MCO must meet the delivery network requirements as specified in 42 CFR 438.206 (b), as well as establish mechanisms to ensure that network providers comply with the State standards of timely access. MCO must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Standards for access and timeliness are identified in the table below.

| General | Maternity |
|---|---|
| • Emergency Services - available twenty-four (24) hours a day, seven days a week<br>• Urgent Care – within twenty-four (24) hours<br>• Non-Urgent Symptomatic - within seven (7) calendar days of initial request.<br>• Routine, Non-Urgent or Preventative Care Visits – within thirty (30) calendar days of initial request. | • First Prenatal Appt- *First trimester* - within fourteen (14) days of initial request<br>• First Prenatal Appt- *Second trimester* - within seven (7) calendar days of initial request<br>• First Prenatal Appt- *Third trimester* – within seven (7) calendar days of initial request |

The MCO must provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to Members promptly and without compromise to the quality of care. The MCO must monitor this regularly to determine compliance and take corrective action if there is a failure to comply.

**Assurances of Adequate Capacity and Services (42 CFR 438.207)**
The MCO shall provide an appropriate range of covered services adequate for the anticipated number of Members for the service and that the MCO maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area.

The MCO shall report network capacity data annually, upon request, and at any time there has been a significant change in the MCO's operations that would affect adequate capacity or services, including changes in services, benefits, payments, or enrollment of a new population.

**Time and Distance Standards (42 CFR 438.68)**
The MCO's network of Providers shall meet the following distance standards in this table in every service area.

| Municipality of Anchorage | Matanuska – Susitna Borough (Rural) | Matanuska – Susitna Borough (Urban) |
|---|---|---|
| • PCP – Within 50 miles or 60 minutes of Member residence | • PCP – Within 150 miles or 180 minutes of Member residence | • PCP – Within 75 miles or 90 minutes of Member residence |
| • Obstetrics – Within 50 miles or 60 minutes of Member residence | • Obstetrics – Within 150 miles or 180 minutes of Member residence | • Obstetrics – Within 75 miles or 90 minutes of Member residence |
| • Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services - Within 50 miles or 60 minutes of Member residence | • Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services - Within 150 miles or 180 minutes of Member residence | • Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services - Within 75 miles or 90 minutes of Member residence |
| • Hospital – Within 50 miles or 60 minutes of Member residence | • Hospital – Within 150 miles or 180 minutes of Member residence | • Hospital – Within 75 miles or 90 minutes of Member residence |
| • Specialists, Adult and Pediatric - Within 50 miles or 60 minutes of Member residence | • Specialists, Adult and Pediatric - Within 150 miles or 180 minutes of Member residence | • Specialists, Adult and Pediatric - Within 75 miles or 90 minutes of Member residence |
| • Pediatric Dentist and Adult Dentist- Within 50 miles or 60 minutes of Member residence | • Pediatric Dentist and Adult Dentist- Within 150 miles or 180 minutes of Member residence | • Pediatric Dentist and Adult Dentist- Within 75 miles or 90 minutes of Member residence |

## Measurement and Improvement Standards

### Practice Guidelines (42 CFR 438.236)

The MCO shall adopt health practice guidelines known to be effective in improving health outcomes. Practice guidelines shall be based on valid and reliable clinical evidence or a consensus of providers in the particular field.

When possible, the MCO shall develop guidelines based on the United States Preventive Services Task Force (USPSTF) as the primary source. The MCO may adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations or National Institute of Health Centers and Institutes. If the MCO does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines. The guidelines shall:

- Be age appropriate to address the special needs or considerations that are driven by age.
- Consider the needs of Members and support family involvement in care plans.
- Be adopted in consultation with contracting health care professionals within the State of Alaska.
- Be reviewed and updated at least every two years and more often if national guidelines change during that time.
- Be disseminated to all affected providers and, upon request, to DHSS, Members and potential Members (42 CFR 438.236(c)).
- Be distributed to affected providers within sixty (60) calendar days of adoption or revision, identifying which specific guidelines are newly adopted or revised, and distributed to new providers. If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers. If the MCO uses fax or e-mail to disseminate the guidelines, it must use an alternative method for those providers that do not have fax or e-mail access.
- Be the basis for and are consistent with decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply (42 CFR 438.236(d)).

### Quality Assessment and Performance Improvement Program (42 CFR 438.240)

The MCO shall have and maintain a quality assessment and performance improvement (QAPI) program for the health services it furnishes to its Members that meets the provisions of 42 CFR 438.330(a)(1).

The MCO shall define its QAPI program structure and processes and assign responsibility to appropriate individuals and shall include the following elements:

- A written description of the QAPI program including identification and description of the roles of designated physical health practitioners.
- A Quality Improvement (QI) Committee that oversees the quality functions of the MCO.
- An annual quality work plan, including objectives for serving individuals with special health care needs and Members from diverse communities.
- An annual written report of the overall evaluation of the effectiveness of the MCO's QAPI program (42 CFR 438.240(e)(2)).
- Evidence of oversight of delegated entities responsible for quality improvement.

Upon request, the MCO shall make available to providers, Members, or DHSS, the QAPI program description and information on the MCO's progress towards meeting its quality plans and goals.

**Performance Improvement Projects (42 CFR 438.340(b)(3)(ii))**

The MCO shall have an ongoing program of performance improvement projects (PIPs), including any required by the State or CMS, that focus on clinical and non-clinical areas (42 CFR 438.330)(b)(1). Through ongoing measurements and intervention, the PIP's must be designed to achieve significant improvements in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

The MCO shall report the status and results of all required clinical and non-clinical performance improvement projects to DHSS at a frequency determined by DHSS (42 CFR438.330).

**Diabetes Prevention Program**

The MCO shall implement an evidence-based Diabetes Prevention Program (DPP) for eligible Members using a Centers for Disease Control and Prevention (CDC)-approved curriculum or a comparable curriculum of the MCO's design. The DPP will be a lifestyle change program designed to assist Members diagnosed with prediabetes in preventing or delaying the onset of type 2 diabetes.

Participation in the DPP shall be available to eligible Members who meet all of the requirements specified in Section 7.3 of the model contract. The MCO shall submit to DHSS a program overview for the proposed DPP program for approval, no later than 1st of April, 2019 and shall provide an annual report of all DPP activities.

**Value Based Purchasing (VBP)**
Value-based contracts should be incorporated into the MCO's network program that promote added value for Members and providers. Value is captured through programs that improve outcomes and lower costs. For purposes of this managed care plan, value-based contracts are defined as payment and contractual arrangements with providers that include two components: provisions that introduce contractual accountabilities for improvements in defined service, outcome, cost or quality metrics, and payment methodologies that align providers financial and contractual incentives with those of the MCO through mechanisms that include, but are not limited to, performance bonuses, capitation, shared savings arrangements, etc.

No later than the 31st of January, 2020, the MCO must submit to DHSS for its review and approval, a plan for implementing value-based purchasing agreements in the second and subsequent years of the contract. The VBP plan shall describe how the MCO plans to achieve the requirements of Attachment 2 of the model contract, and meet the general expectation to reward providers based on achieving quality and outcomes.

The MCO shall share performance and claims data and lists of attributed Members with providers on a quarterly basis for the Membership that is attributed to the provider in VBP arrangements, as well as notify DHSS of any risk-sharing agreements it has negotiated with a provider within thirty (30) calendar days of any contract signing with the provider. Any provider contract that includes capitation payments must require the submission of encounter data within a DHSS approved timeframe.

**Transition of Care (42 CFR 438.62(b))**
The model contract specifies that the MCO will implement a transition of care policy that is consistent with federal requirements and at least meets the State defined transition of care policy. The MCO shall ensure that transitional care services described in the model contract are provided to all Members who are transitioning from settings of care, including appropriate discharge planning. The MCO will develop operational agreements with State and community hospitals, assisted living facilities, and inpatient psychiatric treatment centers to facilitate Member care transitions. The written agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge screening tool. The tool shall encompass a risk assessment for re-hospitalization.

- Development of an individual Member plan to mitigate the risk for re-hospitalization.

- Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage Members that do not receive post discharge care.

- Scheduled follow-up appointments in place at Member discharge;
- Organized post-discharge services, such as after-treatment services and therapy services;
- Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following Member discharge;
- Information on what to do if a problem arises following discharge;
- Coordination with the facility before discharge to coordinate transition;
- For Members at high risk of re-hospitalization, contact with the Member within seven (7) calendar days post-discharge to support: discharge instructions, assess the environment for safety issues, conduct medication reconciliation, assess adequacy of support network and services, and linkage of the Member to appropriate referrals;
- Scheduled outpatient primary care visits within seven (7) calendar days of discharge.
- Planning that actively includes the patient and family caregivers and support network in assessing needs.

## *Section IV: Improvements and Interventions*

Interventions for improvement of quality activities are varied and based on the ongoing review and analyses of results from each monitoring activity by the State and EQRO. As results from assessment activities are produced, it is likely that DHSS will be able to further and more clearly define interventions for quality improvement as well as progress towards objectives.

The State's EQRO reports will include an assessment of the MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, recommendations for improving the quality of health care services furnished by the the MCO, and an assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This information will be used to inform any needed benefit changes, MCO contract amendments, additional MCO quality improvement activities, sanctions, or other program changes. Additionally, the EQRO report will be used to inform the State of any needed oversight or regulatory support to improve managed care health care delivery.

**Sanctions**

If the MCO fails to meet one or more of its obligations under the terms of the model contract or other applicable law, DHSS may impose sanctions as described in this section.

DHSS shall notify the MCO of any default in writing, and shall allow a cure period of up to thirty (30) calendar days, depending on the nature of the default. If the MCO does not cure the default within the prescribed period, DHSS may withhold payment, assignments, or re-enrollments from the end of the cure period until the default is cured or any resulting dispute is resolved in the MCO's favor.

DHSS, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with applicable law, including but not limited to:

- Failing to provide medically necessary services that the MCO is required to provide, under law or under this Contract, to a Member covered under the Contract.

- Imposing premiums or charges on members that are in excess of the premiums or charges permitted under law or under this Contract. If the State imposes a civil monetary penalty on the MCO for charging premiums or charges in excess of the amounts permitted under Medicaid, the State will deduct the amount of the overcharge from the penalty and returns it to the affected enrollee (42 CFR 438.704(c))

- Acting to discriminate against Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a Member, except as permitted under law or under this Contract, or any practice that would reasonably be expected to discourage enrollment by Members whose medical condition or history indicates probable need for substantial future medical services.

- Misrepresenting or falsifying information that it furnishes to CMS, DHSS, a Member, potential Member, a health care provider, or any of its subcontractors.

- Failing to comply with the requirements for physician incentive plans.

- Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHSS or that contain false or materially misleading information (42 CFR 438.700(c)).

- Failing to meet specified reporting deadlines for certified and accurate reports, as required in the model contract.

- Violating any of the other requirements of sections 1903(m), 1932, or 1905(t)(3) of the Social Security Act, and any implementing regulations (42 CFR 438.700(d)(1 - 2)).

- DHSS may base its determinations regarding the MCO's conduct on findings from onsite surveys, Member or other complaints, financial status, or any other source.

Intermediate sanctions may include:

- Civil monetary sanctions in the following amounts (42 CFR 438.704(b - c)):
    - A maximum of $25,000 for each determination of failure to provide medically necessary services; misrepresentation or false Statements to Members, potential Members or healthcare providers; imposes premiums or charges in excess of those permitted in the Medicaid program; failure to comply with physician incentive plan requirements; or marketing violations.
    - A maximum of $100,000 for each determination of discrimination, misrepresentation, or false Statements to CMS or DHSS.
    - A maximum of $15,000 for each potential Member DHSS determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit.
    - A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to Members that are not allowed under managed care. DHSS will deduct from the penalty the amount charged and return it to the Member.
    - A maximum of $5,000 for failure to submit accurate, certified reports by the required deadlines per Attachment 3 of the model contract.
    - A maximum of $5,000 for failure to submit accurate, certified encounter data by the required deadlines per Section 8.22 of the model contract.
- Appointment of temporary management for the MCO as provided in 42 CFR 438.706. DHSS will only impose temporary management if it finds that the MCO has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438.700.
- Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. DHSS shall notify current Members of the sanctions and that they may terminate enrollment without cause at any time. (42 CFR 438.702(a)(5))
- Suspend payments for new enrollments to the MCO until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. (42 CFR 438.702(b))

- Suspension of payment for Members enrolled after the effective date of the sanction and until CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

- When, and for so long as, payment for those Members is denied by CMS. CMS may deny payment to the State for new enrollees if its determination is not timely contested by the MCO. (42 CFR 438.726(b))

### *Section V: Conclusion*

The Quality Strategy is a compilation of State, community and MCO activities aimed at improving the overall health, and healthcare of Alaskans. By investing in changes to the current Medicaid model of care, the State is hoping to achieve the triple aim of coordinating and integrating services, improving quality of care, and achieving cost-savings through value based care.
The Quality Strategy provides a description of the managed care quality program, including standards for safe, effective, quality health care. The MCO model contract includes information on the monitoring process, protocols, and strategies DHSS uses to ensure compliance with the standards, and a description of how DHSS complies with federal Medicaid requirements, including external quality review.

A variety of means are used to ensure compliance and improved clinical quality performance over time; this includes ongoing and annual audits, reports, and other types of reviews to assess how the strategy is working and to institute any necessary corrective actions. DHSS uses the information obtained through monitoring and evaluation activities to improve the quality program for Medicaid managed care and achieve the mission of patient centered care for the people of Alaska.