MEDICAID 101: 2021 EDITION

An Overview of West Virginia's Medicaid Program

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
MEDICAL SERVICES

Medicaid: The basics

Medicaid is a public benefit program that provides health insurance that enables eligible individuals to obtain health care services. Medicaid is co-financed by state and federal governments and is administered by states. In West Virginia, the Bureau for Medical Services (BMS) within the West Virginia Department of Health and Human Resources (DHHR) is the state agency solely responsible for administering the West Virginia Medicaid program.

Across the country, Medicaid is the nation's single largest health insurer, covering more than 69.8 million individuals in August 2020 or approximately 20.9% of the US population.[1] National Medicaid enrollment increased by 6.6% between August 2019 and July 2020.[1] Medicaid contributes substantially to the financing of the US health care system, supporting local public health infrastructure, hospitals, mental health centers, at-home-care, community clinics, nursing homes, physicians, allied health professionals, health care workers, and health care administrators.

The Medicaid program is critical to the health and well-being of hundreds of thousands of West Virginians. As of August 2020, 535,129 individuals were enrolled in the West Virginia Medicaid program, accounting for nearly 30% of the state's total estimated population in 2019.[2] Medicaid enrollment in West Virginia increased by nearly 5% from January 2019 to September 2020.[3]

This manual provides a brief overview of the West Virginia Medicaid program, including how it is financed, Medicaid care delivery systems, covered services, and trends in Medicaid enrollment and spending. This manual begins by refreshing information presented in the 2019 West Virginia Medicaid 101 Manual.[4] It also covers two topics of special interest in 2021: Medicaid policies implemented in response to the COVID-19 pandemic and an overview of the Mountain Health Promise Program.

The information in this manual should not be considered as Medicaid policy. Rather, this manual is intended to serve as an accessible resource to answer frequently asked questions related to the West Virginia Medicaid program. Data sources used in the creation of this manual are listed in the references section. For additional information related to the Medicaid program, or questions on any of the information in this manual, please see the contact information in the Appendix.

MEDICAID VS. MEDICARE

Medicaid: A public assistance program that serves low-income people of all ages. Medicaid is jointly funded by states and the federal government but is administered by states. Patients with Medicaid usually do not have out-of-pocket costs related to covered medical expenses.

Medicare: An insurance program funded and administered by the federal government. Medicare provides health insurance for hospital and medical care to seniors age 65 and older and some individuals under age 65 with disabilities. Medicare beneficiaries typically have some out-of-pocket costs.

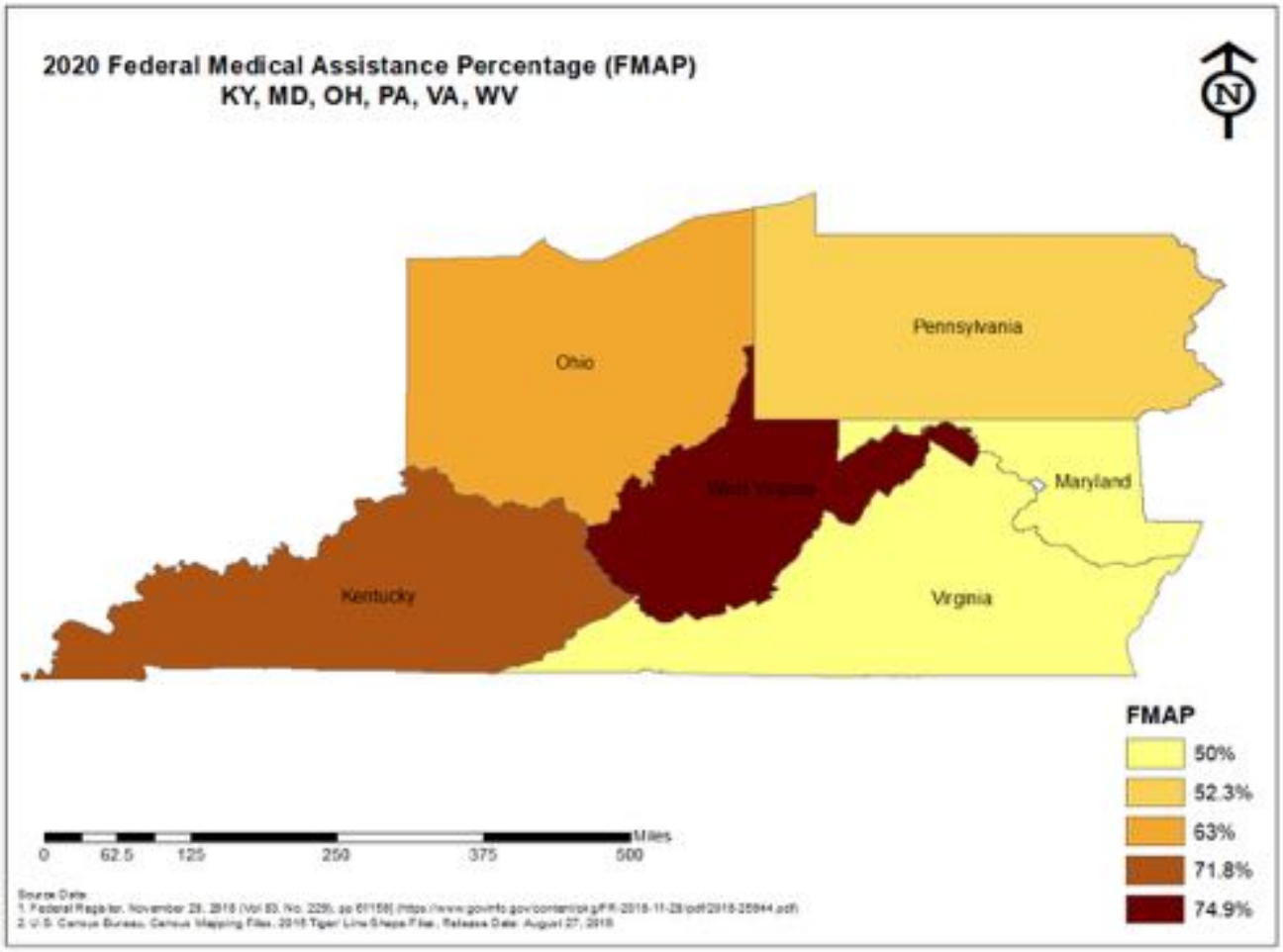
Who pays for Medicaid?

A state-federal partnership

Medicaid is jointly funded by state and federal governments. The majority of Medicaid funding is provided by the federal government. The federal government shares financial responsibility for the Medicaid program by matching state spending with federal dollars. The federal share of those costs is determined by the Federal Medical Assistance Percentages (FMAP). The FMAP is calculated annually using a formula set forth in federal statute and is inversely proportional to a state's per capita income relative to the US average. States with lower per capita incomes have higher FMAPs.[5]

As seen in Figure 1, West Virginia has the highest FMAP in the region. By law, the national FMAP range is no less than 50% and not higher than 83%.

Figure 1: Fiscal year 2020 FMAP in West Virginia and surrounding states



In fiscal year 2020, West Virginia's FMAP was 74.9%.[5] This means that the federal government pays for 74.9% of the costs for eligible Medicaid services, while BMS is only responsible for 25.1% of the costs. In practice, if a Medicaid member has a hospital stay that results in $1,000 in costs, the federal government will pay $749, while BMS will pay only $251. In this sense, the FMAP acts as a multiplier

for state spending. For example, in West Virginia, every $100 spent by the state on Medicaid services the federal government will match it up to $298.

These matching funds directly benefit patients receiving health care services while also helping to finance the health care infrastructure in areas with large Medicaid eligible populations. States may also receive an enhanced FMAP (eFMAP) for covering certain services or populations. The Affordable Care Act provided an increased FMAP to states that expanded Medicaid eligibility to nonelderly adults with income up to 138% of the federal poverty level (FPL).[6]

The Affordable Care Act took full effect in 2014. Since that time, the effects of Medicaid expansion on Medicaid coverage, access to care, and other economic measures have been studied by researchers, policymakers, and other stakeholders. The Kaiser Family Foundation (KFF) developed a descriptive brief in March 2020 summarizing and reviewing the outcomes of 404 studies collected from academic health and social policy search engines such as PubMed and related government organizations. Studies generally found that Medicaid expansion was associated with improvement in coverage, access to care, and increased utilization of services. Economic impact studies pointed to state budget savings, reductions in uncompensated care costs, as well as increases in employment and revenue. More recent studies also showed associations with decreased mortality rates for certain conditions and improvements in self-reported health status of enrollees.[7,8] The brief published by KFF includes a complete bibliography of the 404 studies.

In addition to the eFMAP for the population covered by Medicaid expansion, states may also receive an eFMAP if they utilize Children's Health Insurance Program (CHIP) funds to expand their Medicaid programs as opposed to utilizing Medicaid funds for expansion. For fiscal year 2021, West Virginia's eFMAP for the CHIP program will be 82.5%. The eFMAP is calculated and applied to reduce the state share under the FMAP, but cannot exceed 85%.[5]

In addition to the FMAP and eFMAP, an Emergency FMAP has been established under the Families First Coronavirus Response Act of 2020 which, on a temporary basis, increases states' current FMAP and eFMAP by 6.2 percentage points. This increase, enacted by the Secretary of the U.S. Department of Health and Human Services, is retroactive to January 1, 2020 and will expire at the end of the emergency period. West Virginia's Emergency FMAP is 81.1% and the Emergency eFMAP for CHIP is 98.3%. The end date of the emergency period has yet to be announced.[5]

Medicaid care delivery systems

States are generally authorized to set standards and create policies for delivering medical and pharmacy services to Medicaid enrollees. States can determine how services are purchased and how payments are distributed to Medicaid providers. The two most common care delivery systems are fee-for-service and managed care.

Fee-for-service: Medicaid providers are paid a flat fee for each service delivered.

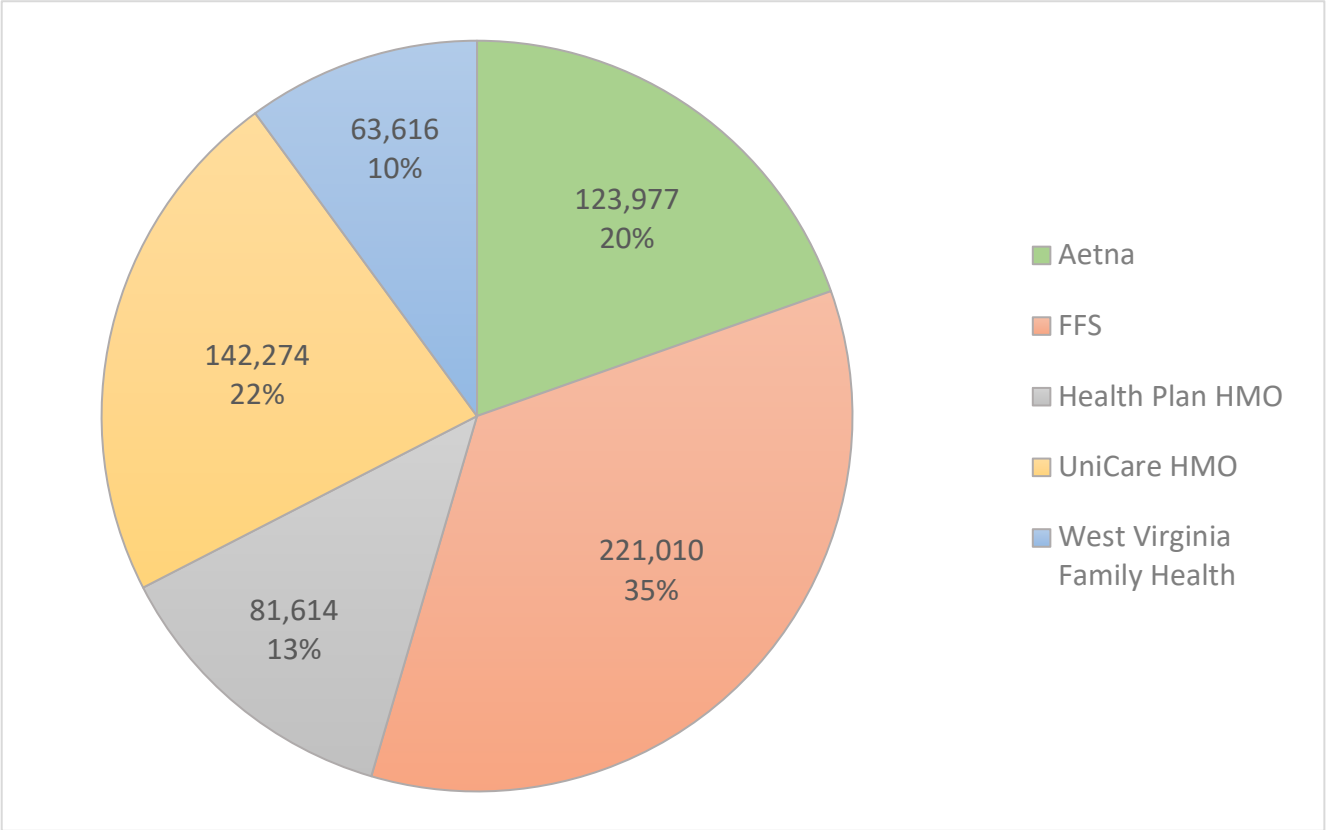
Managed care: States contract with health insurance plans or managed care organizations (MCOs) to provide coverage for Medicaid enrollees. These organizations receive a monthly per-member capitation as payment for Medicaid services provided.

Medicaid care delivery in West Virginia

Most Medicaid beneficiaries in West Virginia receive the majority of their benefits via the managed care delivery system through the Mountain Health Trust program. In 2019 the Mountain Health Trust Program contracted with four MCOs for the provision of medical benefits: Aetna, Health Plan HMO, UniCare HMO, and West Virginia Family Health. West Virginia Family Health's contract with West Virginia's Medicaid program expired on June 30, 2019. In 2019, there were 632,491 individuals enrolled in Medicaid with 65.1% receiving benefits via managed care and 35% receiving fee-for-service care delivery. Figure 2 below shows the number of individuals enrolled in managed care and fee-for-service in 2019.[9]

Individuals who are not covered by an MCO receive all benefits via the fee-for-service delivery system and are typically eligible for Medicaid through a waiver program such as the Intermediate Care Facilities/Individuals with Intellectual Disabilities Waiver or the Traumatic Brain Injury (TBI) Waiver. Individuals may also be enrolled in fee-for-service when they initially enroll in Medicaid, but most are later transferred to one of the contracted MCOs. Importantly, some Medicaid benefits, including pharmacy benefits, long-term care services, and non-emergency medical transportation are still paid via the fee-for-service delivery system for all Medicaid beneficiaries.

Figure 2: Medicaid beneficiaries enrolled in each MCO in calendar year 2019 [9]



Source: West Virginia Medicaid Data – 2019 Eligibility Data

Covered benefits and services

The federal government requires every state Medicaid program to cover a specific set of benefits and services. The services that programs are required to cover have changed greatly since the Medicaid program's inception in 1965 due to advancements in medical technologies and changes in the makeup of the Medicaid eligible population. In addition to the required covered services, states are allowed some flexibility in terms of offering additional benefits so long as services are equitable in terms of availability and scope for all Medicaid beneficiaries.[10]

Medicaid in West Virginia is federally required by the Centers for Medicare and Medicaid Services to cover the following services:[11]

- Inpatient and outpatient hospital services
- Early and periodic screening, diagnostic and treatment services for children, including dental services
- Nursing facility services
- Laboratory and x-ray services
- Home health services including nursing services, home health aides, and medical supplies and equipment
- Physician services

- Rural health clinic services
- Federally qualified health center services
- Family planning services and nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services when licensed or otherwise recognized by the state
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

West Virginia's Medicaid program also covers the following optional services: [11]

- Alcohol and drug treatment
- Chiropractic services
- Emergency dental care for adults
- Orthodontics for children
- Emergency hospital services
- Post-cataract eyeglasses for adults
- Hearing aids for children
- Home care including personal care assistant services
- Hospice care
- Medical equipment and supplies
- Prescriptions and medication therapy management
- Both physical and mental rehabilitative services
- Inpatient and outpatient substance use disorder treatment
- Case management
- Care coordination
- Autism spectrum disorder services

Who is eligible for Medicaid in West Virginia?

West Virginia provides coverage to a wide range of its population. All individuals who meet federally established income eligibility requirements are guaranteed Medicaid coverage. However, states are also allowed some flexibility in terms of eligibility requirements and can extend coverage to certain optional populations.[12] Eligibility requirements may vary for different categories of beneficiaries.[12] This section describes some of the most common Medicaid eligibility categories.

Pregnant women and children

Medicaid provides coverage for adequate prenatal care services to many pregnant women who are otherwise uninsured. Medicaid is also the primary health insurance program for children of low-income households from birth to age 18. By ensuring the health and developmental success of pregnant women and children, Medicaid invests in West Virginia's future. Pregnant women and children are

Medicaid eligible if their family income is below a certain threshold of the Federal Poverty Level (FPL). The FPL threshold for children varies by age and is shown in Figure 3 below.

While Medicaid insures many children in West Virginia, some children receive benefits through the Children's Health Insurance Program (CHIP). CHIP expands health insurance coverage to children in families who have incomes above the Medicaid eligibility threshold without commercial health insurance. Services provided through CHIP are generally comparable to those offered under the Medicaid program, however, states have more flexibility in determining the breadth of coverage for CHIP services. West Virginia's Children's Health Insurance Plan is not considered a Medicaid coverage group, but DHHR determines eligibility based on the child's family income.

Aged and disabled population

Medicaid is the primary insurer for many individuals with mental or physical disabilities. Individuals who are aged, blind, or disabled, and who have limited assets to support themselves may be eligible for supplemental security income (SSI) from the federal government. In West Virginia, all individuals who receive SSI automatically become eligible for Medicaid. Once enrolled, these individuals may receive health care, therapy, and long-term care services with few or no out-of-pocket costs.

Some individuals in this coverage group are also dual-eligible for both Medicaid and Medicare. These beneficiaries may have some or all of their benefits paid by Medicare instead of Medicaid. In these cases, Medicaid is always the payor of last resort. In other cases, Medicaid may pay for some low-income Medicare beneficiaries' co-pays, deductibles and premiums as well as certain medical services. As a result of these policies, Medicaid pays for the majority of nursing home care for West Virginia seniors.

Expansion adults

Historically, adults aged 19-64 without dependent children were not eligible for Medicaid coverage. [13] However, with the passage of the Patient Protection and Affordable Care Act, states were given the option of expanding Medicaid eligibility to adults with incomes up to 138% of the federal poverty level. West Virginia is one of 39 states to expand Medicaid eligibility to this population.[14] The federal government pays an enhanced FMAP[5] for Medicaid services provided to this population.[15]

Non-Expansion adults

BMS also provides Medicaid benefits to some adults who do not fall into any of the categories described above. These "non-expansion" adults may be eligible for a variety of reasons. For example, the Medicaid Work Incentive program provides coverage for individuals aged 16 to 65 who meet the Social Security Disability requirement and who are employed if their income is at or less than 250% of the FPL, and their unearned income is at or below the SSI payment level. Medicaid also provides coverage to parents and caretaker-relatives who reside in the same household as dependents who meet certain income limits. Individuals may also be eligible for Medicaid due to certain medical conditions. For example, women diagnosed with breast or cervical cancer by a Centers for Disease Control and Prevention (CDC) program may qualify for Medicaid coverage if certain conditions are met.

How is Medicaid eligibility determined?

Medicaid eligibility is dependent on a host of factors including household income, family size, age, disability, and citizenship status. The specifications for these criteria vary by eligibility category. For example, pregnant women may make up to 185% of the FPL and qualify for Medicaid eligibility, while adults in the expansion population may only make up to 138% of the FPL.[12] West Virginia Medicaid's income eligibility thresholds, as a percentage of the FPL for various groups, are displayed in Figure 3. Figure 4 displays the 2020 FPL designations for different family sizes; families who make less than this amount are deemed in poverty.

For individuals to receive Medicaid coverage in certain eligibility groups, an annual income test must be passed to determine eligibility for Medicaid benefits. Additionally, several Medicaid programs—including Aged and Disabled Waiver (ADW), Traumatic Brain Injury (TBI) Waiver, Intermediate Care Facilities/Individuals with Intellectual Disability (ICF/IID), and others—require an annual asset test for continued eligibility. Assets include items such as a car above a certain value, personal savings, and life insurance policies. Notably, a family home is not considered an asset for Medicaid eligibility.[12]

Figure 3: Eligibility thresholds as a percent of the FPL for various Medicaid groups[3]

Population	Eligibility threshold as a percent of FPL
Children	
Ages 0 – 1	158%
Ages 1 – 5	141%
Ages 6 – 18	133%
CHIP	300%
Adults	
Aged and Disabled*	Up to 300% of SSI Limit
Expansion population	138%
Pregnant Women	
Medicaid	185%
CHIP Pregnancy (age 19+)	300%

*Eligibility for the aged and disabled population is based on social security income (SSI) limits. Certain individuals can make up to 300% of the SSI limit and qualify for Medicaid benefits.

Figure 4: 100% FPL by household size in 2020[11]

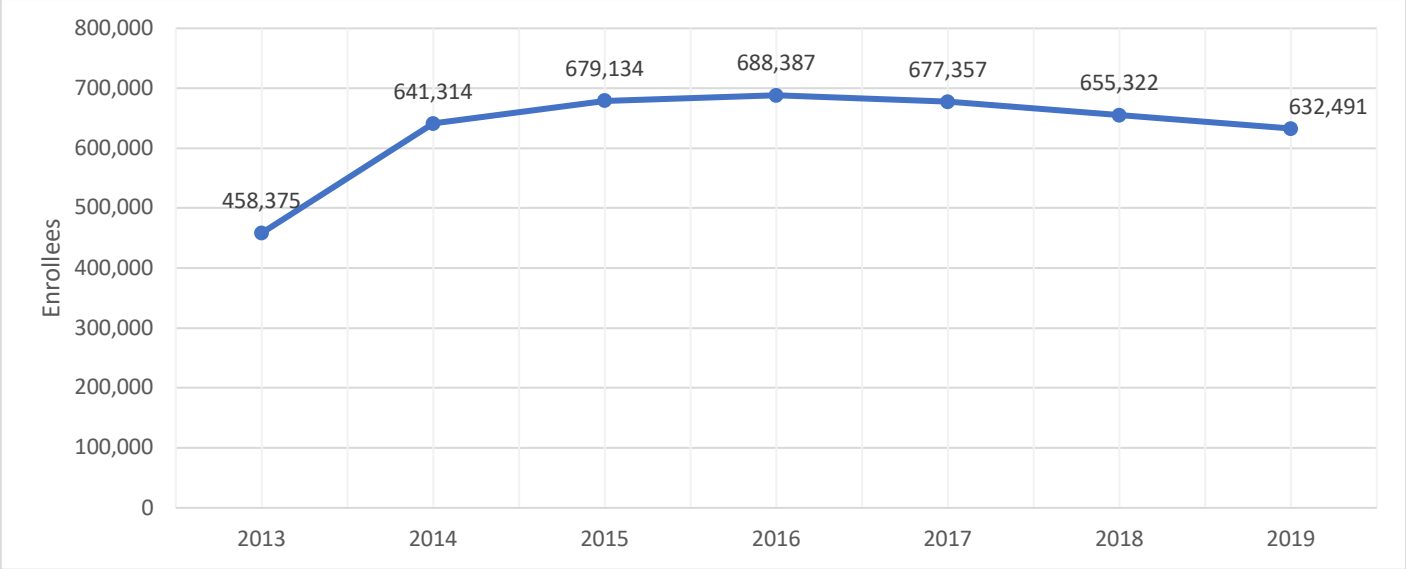
Household Size	FPL Threshold
Individuals	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120

*Households generally include a tax filer, their spouse, and any tax dependent children. For families/households with more than 8 persons, add $4,420 for each additional person.

Medicaid enrollment by the numbers

Figure 5 displays the number of individuals enrolled with West Virginia Medicaid from 2013 – 2019. Please note that the number of individuals enrolled with Medicaid on any given day will be significantly less than the number enrolled at any point in the calendar year. While there are more than 630,000 unique individuals enrolled in Medicaid at any point in 2019, monthly enrollment only ranged from 528,385 to 534,692.[9]

Figure 5: Total annual Medicaid enrollment, 2013 – 2019

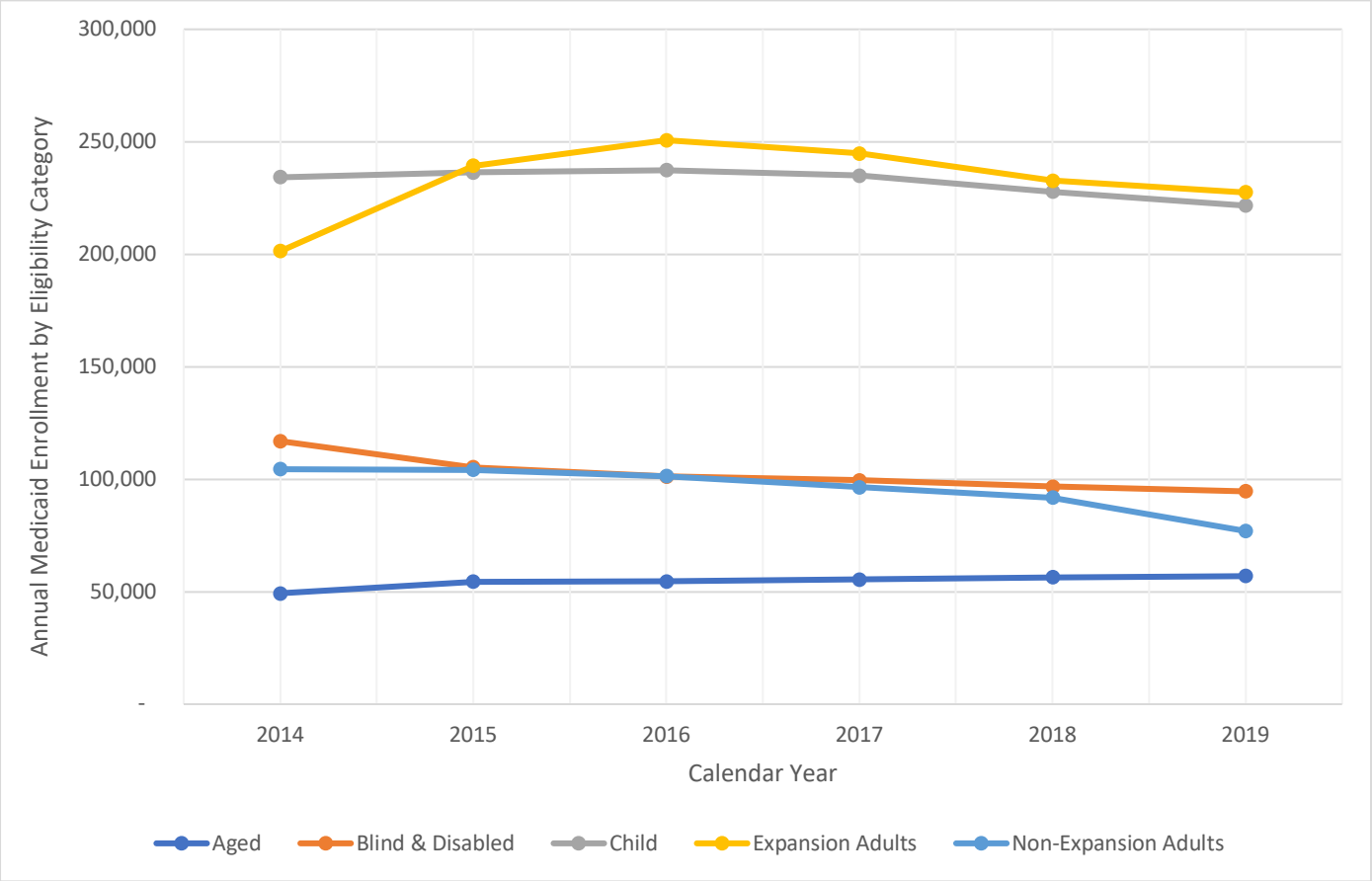


Source: West Virginia Medicaid Data – 2019 Eligibility

In 2019, approximately one-third of West Virginia's population was enrolled in Medicaid at some point during the year.[9,16] From 2013 to 2019, Medicaid enrollment increased by nearly 38% after the state expanded Medicaid eligibility under the Affordable Care Act in 2014. Annual enrollment peaked in 2016 and has declined slightly since then.[9]

Figure 6 displays trends in Medicaid enrollment from 2014 – 2019 by Medicaid eligibility category. Changes in Medicaid enrollment from 2014 – 2019 have been driven almost entirely by the adult expansion population. The number of blind and disabled individuals and children enrolled in Medicaid has decreased slightly from 2014 – 2019.[9]

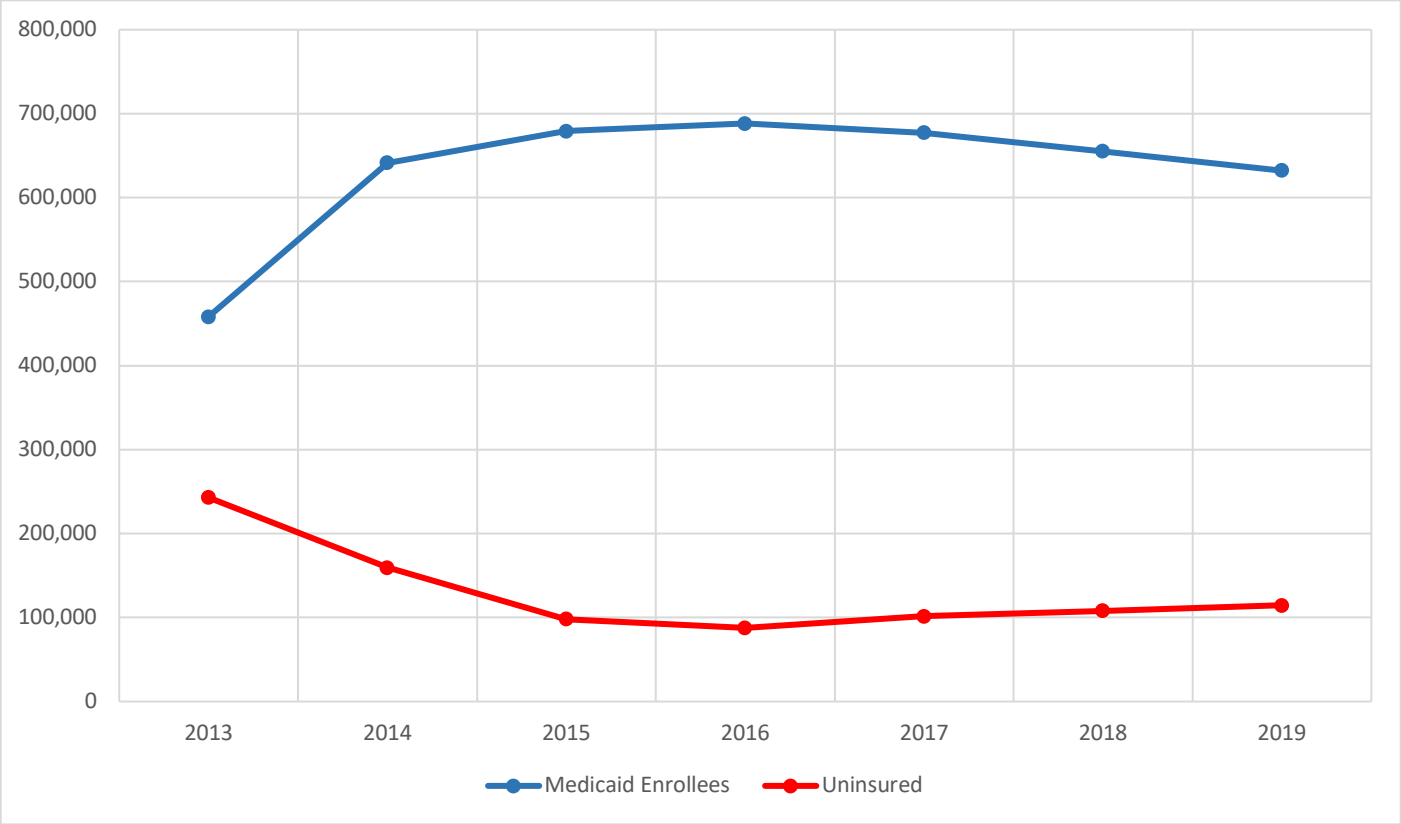
Figure 6: Annual Medicaid enrollment by eligibility group, 2014 – 2019 [9]



Source: West Virginia Medicaid Data – 2019 Eligibility, Facility, Professional and Drug Datasets

Figure 7 displays trends in the percentage of West Virginians with various types of insurance coverage relative to the percent of uninsured West Virginians. Increases in Medicaid enrollment following Medicaid expansion coincided with a dramatic decrease in the number uninsured West Virginians. West Virginia now has a low uninsured rate of 6.6%, compared with the national uninsured rate of 9.2% in 2019. State uninsured rates ranged from 3.0% (District of Columbia) to 18.4% (Texas), with West Virginia ranked 18th out of the 52 US states and territories.[17]

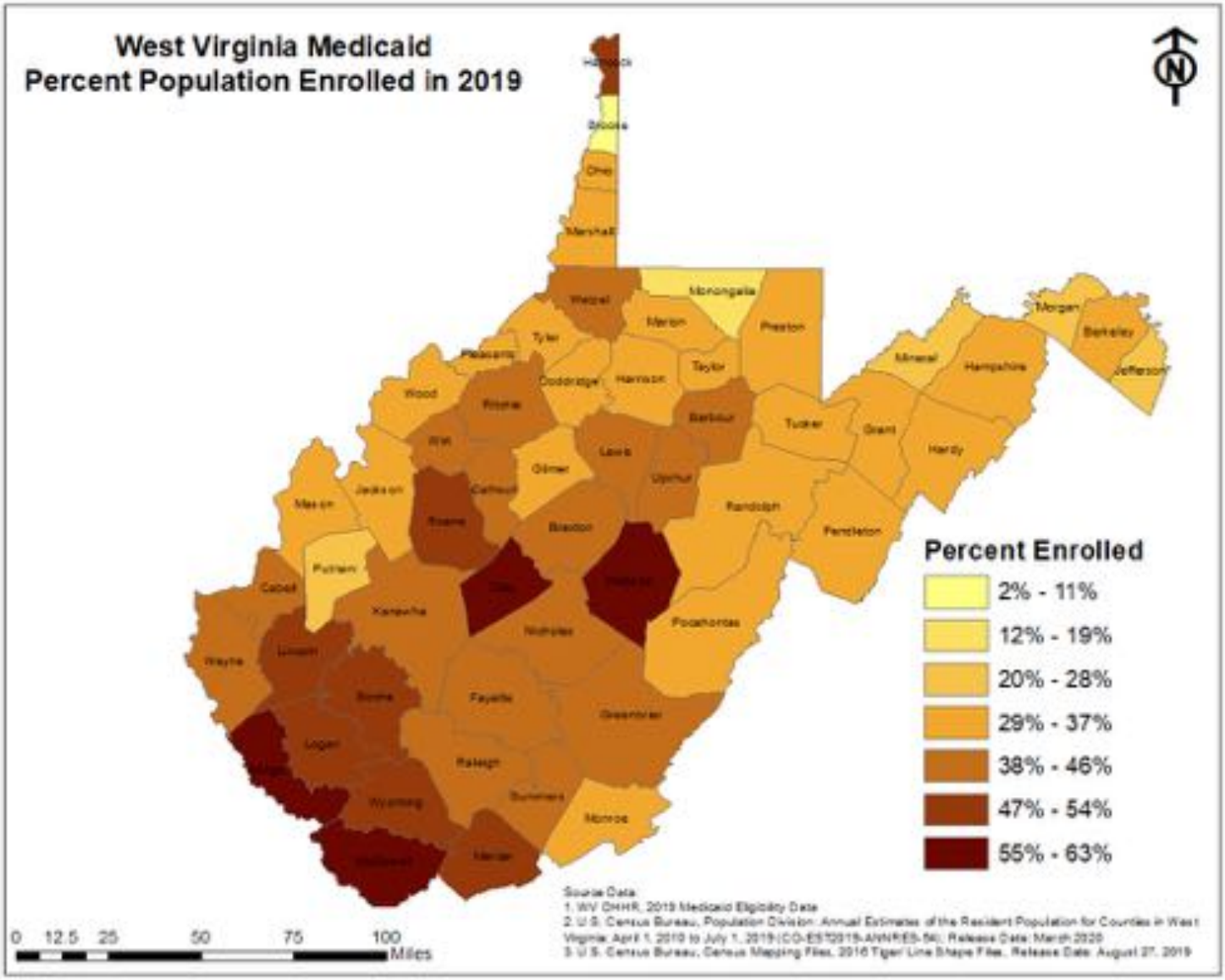
Figure 7: Percent of insured vs uninsured West Virginians, 2010 – 2019 [8, 9]



Source: West Virginia Medicaid Data – 2019 Eligibility & Kaiser Family Foundation

Figure 8 displays the percent of individuals enrolled in Medicaid in each county in West Virginia during calendar year 2019. Counties in the southern region of the state generally had higher rates of Medicaid coverage relative to counties in the northern region or eastern panhandle.

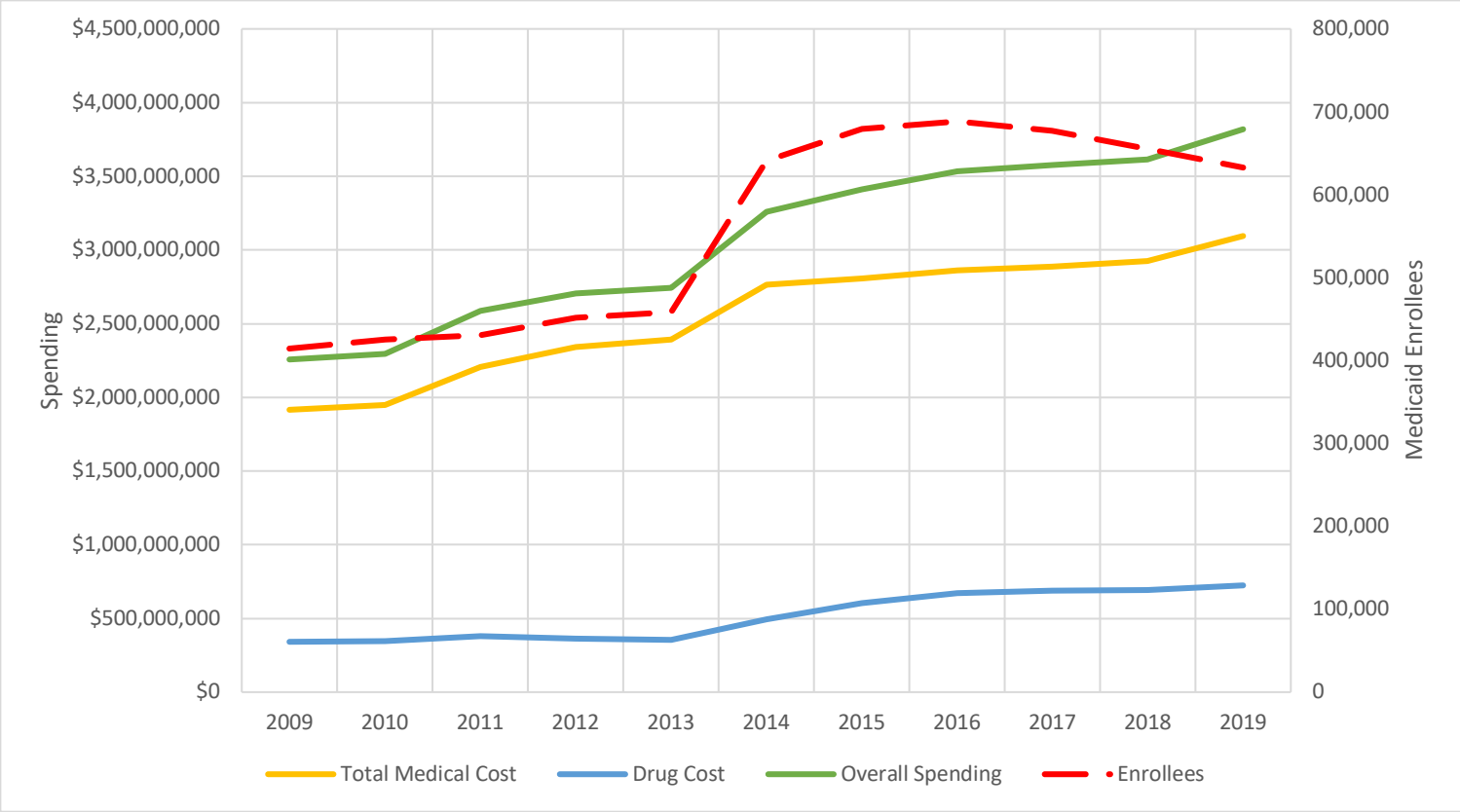
Figure 8: Percent individuals with Medicaid coverage in WV by county, 2019



Medicaid spending by the numbers

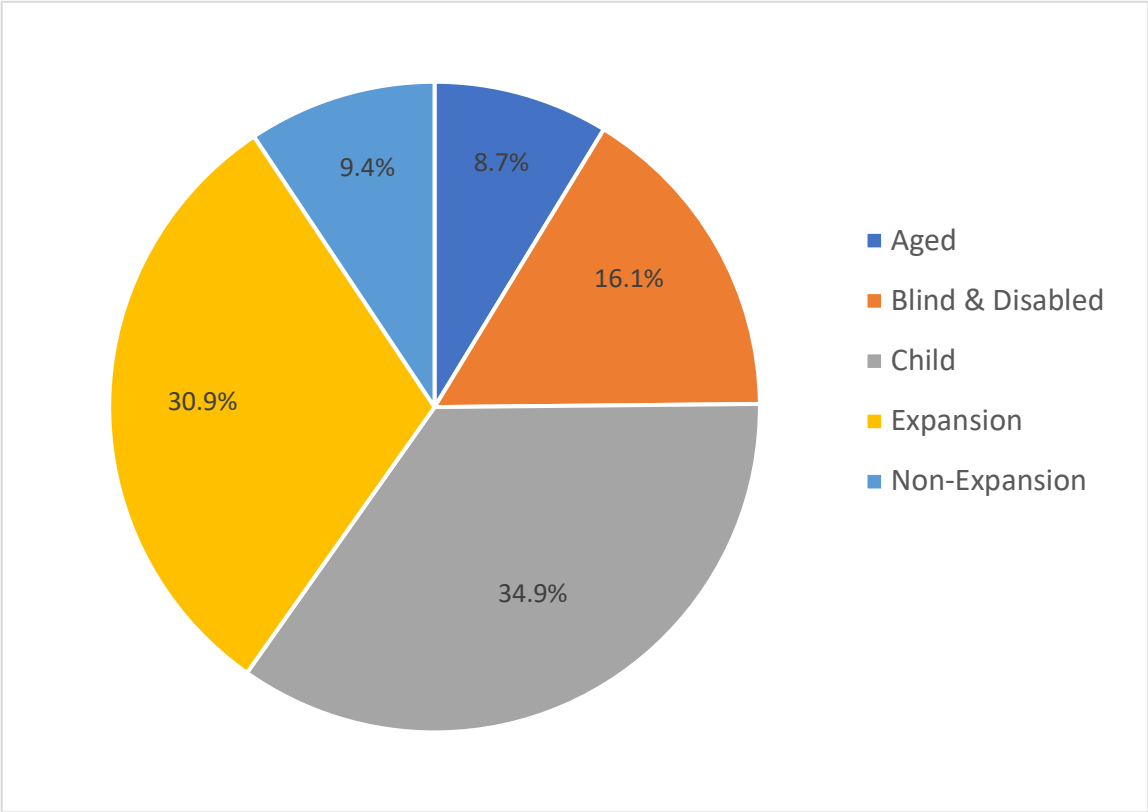
Figure 9 displays trends in annual Medicaid enrollment and spending from 2009 – 2019. Annual Medicaid enrollment increased substantially following implementation of Medicaid expansion under the Affordable Care Act in 2014 which also resulted in increases in Medicaid spending. Medicaid enrollment increased by 52.6% from 2009 to 2019, and total Medicaid spending increased by 69.2% over the same period. Increases in Medicaid spending were primarily driven by increased spending on medical claims and not increased spending on pharmacy claims. Notably, Medicaid spending increased between 2018 and 2019, while Medicaid enrollment decreased for the same period. [9]

Figure 9: Annual Medicaid enrollment and spending, 2009 – 2019 [9]



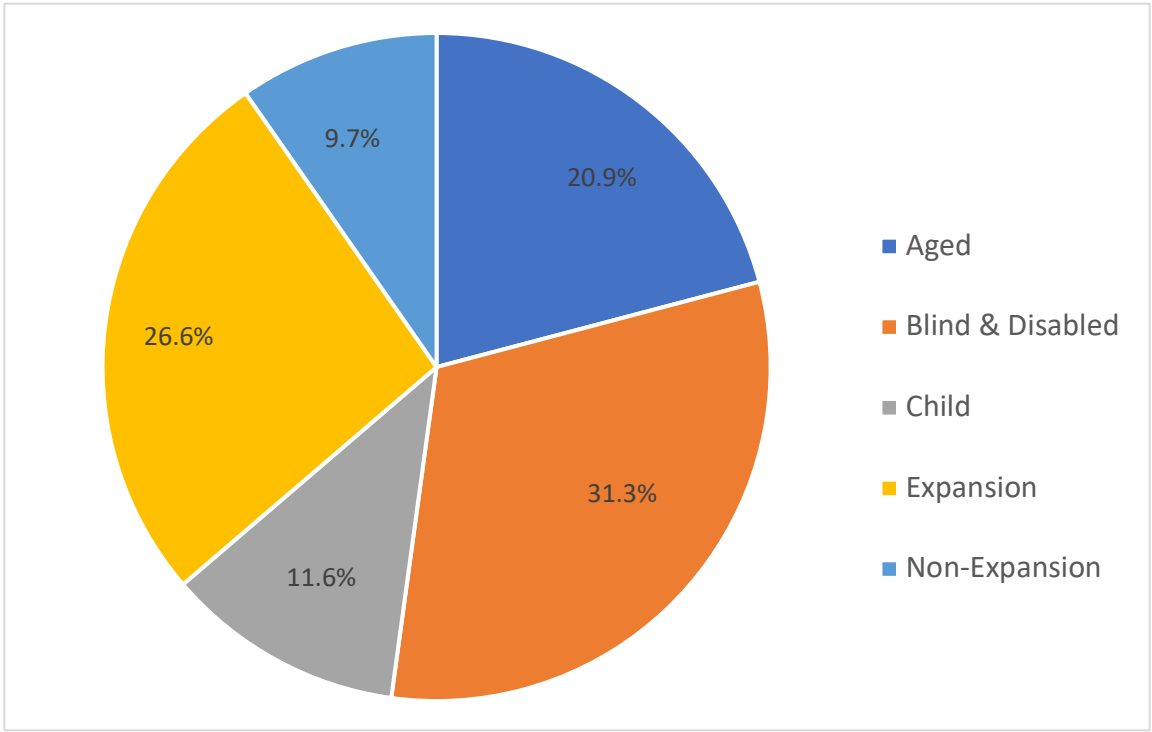
Source: West Virginia Medicaid Data – 2019 Eligibility, Facility, Professional and Drug Datasets

Figure 10A: Percent of Medicaid beneficiaries in different eligibility categories, 2019 [9]



Source: West Virginia Medicaid Data – 2019 Eligibility, Facility, Professional and Drug Datasets

Figure 10B: Medicaid spending by eligibility categories in 2019 [9]

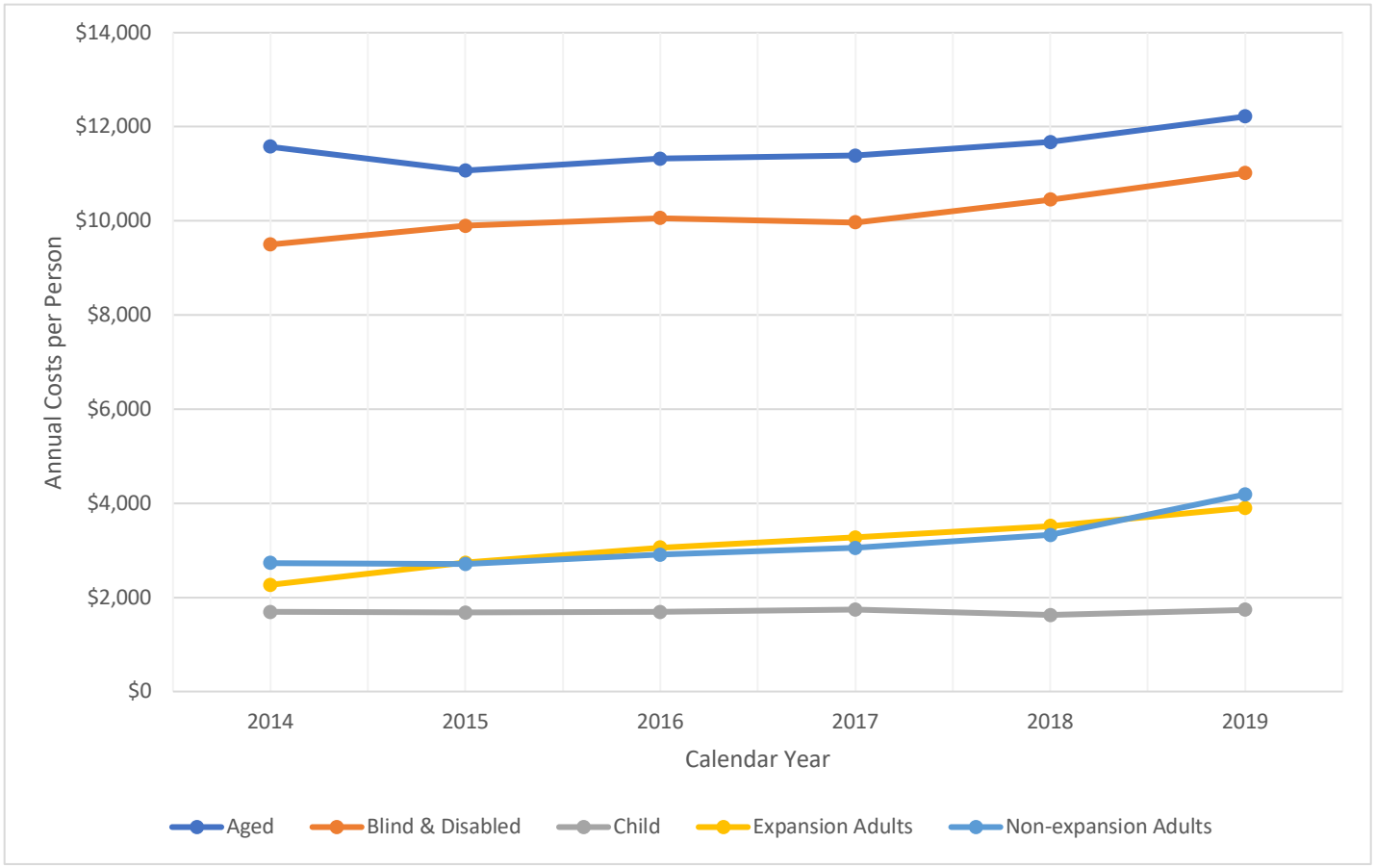


Source: West Virginia Medicaid Data – 2019 Eligibility, Facility, Professional and Drug Datasets

Figure 10A compares the percent of Medicaid beneficiaries in different eligibility categories in 2019 relative to the percent of Medicaid spending attributable to each group, as depicted in Figure 10B. While the adult expansion population has largely driven increases in Medicaid enrollment, this population accounts for a relatively small proportion of total Medicaid spending. In 2019, 31.0% of Medicaid beneficiaries were part of the adult expansion population (n=164,914); however, these individuals accounted for only about 26.6% of total Medicaid spending during the calendar year. Meanwhile, the aged population (n=47,447) and the blind and disabled populations (n=85,385) together comprised only about 25.0% of the Medicaid population in 2019, and they accounted for approximately 20.9% of all Medicaid spending. The aged population and the blind and disabled Medicaid populations tend to have special health care needs and require more frequent Medicaid services than other groups. Therefore, it is expected that the expansion population accounts for a smaller proportion of Medicaid spending relative to populations with greater health care needs.

Figure 11 displays average Medicaid spending per person by eligibility group. Individuals in the aged population (n=47,447) and the blind and disabled Medicaid population (n=85,385) account for higher per person spending than individuals in other eligibility groups. Beneficiaries in the aged population and blind and disabled population accounted for two to four times greater average spending per person relative to beneficiaries in any of the other eligibility groups and this was consistent from 2014 – 2019. [9]

Figure 11: Medicaid spending per person by eligibility group



Source: West Virginia Medicaid Data – 2019 Eligibility, Facility, Professional and Drug Datasets

Special Topics for 2020

Bureau for Medical Services (BMS) response to the COVID-19 pandemic

In December 2019, the novel SARS-CoV-2 coronavirus was identified in Wuhan, China as the virus spreading the highly infectious respiratory disease referred to as COVID-19. On March 11, 2020, the World Health Organization declared the global COVID-19 outbreak a pandemic. Three days later, the Trump Administration declared a national emergency in response to the COVID-19 outbreak in the United States. The emergency declaration allowed agencies at the federal, state, and local level to take sweeping actions to prevent the spread of the virus and mitigate the impact on morbidity and mortality.

BMS has been heavily involved in the COVID-19 response in West Virginia. BMS implemented many policy changes intended to reduce the risk of Medicaid beneficiaries' and health care providers' exposure to COVID-19 and ensure access to necessary medical equipment and services, both in the initial and ongoing phases of the pandemic.

In response to the COVID-19 pandemic, BMS released over 50 memos and other policy documents between March and September 2020 which describe approximately 132 different policy changes. These policy changes can be organized into 7 overarching domains: behavioral health services, 1135 waiver flexibilities, telehealth, long-term care services, pharmacy services, home and community-based services/waivers, and transportation. Example policy changes related to each of these domains are described in detail below.

Behavioral health services [18]

BMS implemented several policy changes intended to help providers maintain availability of their behavioral health services. BMS waived requirements for face-to-face contact regarding the administration of assertive community treatment (ACT) services from March 16, 2020 to May 31, 2020. BMS also suspended counseling/therapy requirements associated with medication-assisted treatment (MAT) for enrollees with opioid use disorder (OUD) to ensure patients can continue to receive needed medications even if they do not receive concurrent counseling services. BMS increased reimbursement rates paid to behavioral health providers and psychiatric residential treatment facilities (PRTFs) by 20%. This increase helps incentivize providers to take on the increased risks associated with providing necessary mental health rehabilitation services to Medicaid beneficiaries during the COVID-19 pandemic. As part of another policy change, BMS allowed flexibility in the requirement that one of the two staff must be an LPN or higher degree at facilities that provide community psychiatric support treatments, while also authorizing the use of telehealth modalities for medical and clinical staff to render services to members that require acute, intensive services following a crisis to be stabilized utilizing community settings without the need for hospitalization.

1135 Flexibilities [19]

Following the national emergency declaration, BMS leadership communicated to the Centers for Medicare and Medicaid Services (CMS) that there were requirements to various federal Medicaid

policies/programs that posed significant issues or challenges for the West Virginia health care delivery system. As such, BMS requested a waiver or modification to these requirements.
These changes include the extension of state fair hearing appeals timelines, modification of State Plan Amendment (SPA) timelines and public notice requirements of waivers, increased provider coverage through reimbursement of payable claims from out-of-state providers, as well as allowing West Virginia to waive certain provider screening and enrollment requirements.
To prevent delays in service delivery and provider reimbursements, timeframes for tribal consultations and public notice for SPAs were modified to ensure policies can be implemented in a timely manner.

Telehealth [20]

BMS has provided a wide range of guidance to providers regarding the utilization of telehealth modalities for rendering diagnoses and treatments to beneficiaries. In response to the COVID-19 pandemic, BMS made several policy changes to expand the number of services that could be rendered via telehealth. This increased use of telehealth is intended to reduce risk of COVID-19 transmission among providers and patients. These policies included the approval of telehealth for psychological testing and evaluation, preliminary dental examination via teledentistry, and occupational, physical, or speech therapy. Additionally, BMS implemented a policy allowing existing services already approved for telehealth to be conducted using live video conferencing or telephonic services without video capability in the member's home. Finally, BMS allowed for non-emergent evaluation and management visits to be rendered through telehealth modality from enrolled federally qualified health centers/rural health clinic facilities to members' homes.

Long-Term care services [21]

BMS implemented a number of policy changes related to long-term care services in response to the COVID-19 pandemic including the use of swing beds to facilitate acute care hospital discharges and new admissions due to COVID-19, increase of the reimbursement rate for Intermediate Care Facilities by $10 per day, and electronic/telephonic completion of individual program plan meetings for individuals with intellectual disabilities receiving care at intermediate care facilities.

Home and community-based services waivers [22]

The Home and Community-Based Services (HCBS) Waiver programs operated by BMS allow for the provision of a variety of home and community-based services aimed at keeping beneficiaries in their communities rather than institutions. In response to the COVID-19 pandemic, BMS has made a variety of changes to the Aged and Disabled Waiver (ADW) program, Intermediate Care Facilities/Individuals with Intellectual Disabilities Waiver (ICF/IID) program, Traumatic Brain Injury Waiver (TBI) program,

and Children with Serious Emotional Disorder Waiver (CSED) program that aim to provide a continuity in services without depending on the normal face-to-face interactions while also maintaining quality of those services.

Pharmacy services [23]
BMS implemented several policy changes related to covered pharmacy services in response to the COVID-19 pandemic. These changes include a waiver of co-pay requirements for several drugs that may be related to COVID-19 treatment, a waiver of signature requirements for non-controlled substances, and an increase in the maximum days' supply limit to 90 days for non-controlled maintenance medications. Additionally, BMS began to provide limited pharmacy benefits to uninsured individuals who may have contracted COVID-19 to allow these individuals to receive COVID-19 related medications.

Transportation [24]
BMS made several policy changes aimed at incentivizing transportation providers to maintain continuity of their services. The first policy change was the implementation of the A0998 code to increase reimbursement for ambulance transportation to compensate for increased risks during the pandemic. Another policy incentivized collection of specimens for COVID-19 testing by emergency medical services (EMS) providers. Finally, BMS issued guidance for ambulance transportation of suspected or confirmed COVID-19 cases to ensure enrollees have access to transportation in the event they contract COVID-19.

Evaluating the impact of policy changes
Although many of the policy changes that BMS implemented will only remain in place for the duration of the emergency declaration, BMS anticipates that some policy changes would likely continue to benefit Medicaid beneficiaries and providers if they remain in place thereafter. With this in mind, BMS has contracted with the West Virginia University Office of Health Affairs to conduct a comprehensive evaluation of the Medicaid policy response to the COVID-19 pandemic. This evaluation seeks to identify the impact of the Medicaid policy changes on health service utilization, quality of care, spending, and population health outcomes related to morbidity and mortality. At the conclusion of the evaluation, findings will be submitted to the DHHR leadership to assist in policy development to better serve the Medicaid population as well as to shape emergency-preparedness plans for future pandemics and/or other related national emergencies.

Mountain Health Promise Program
The United States Department of Justice (DOJ) notified the state of West Virginia in June 2015 that the state did not comply with Title II of the Americans with Disabilities Act in part due to an excessive number of youth in the foster care system with unnecessarily long lengths of stay in psychiatric residential treatment facilities.[25] To regain compliance, West Virginia agreed to reduce the number of children with serious emotional disorder (CSED) that receive residential treatment by providing community-based services designed to support children and families in the most integrated environment possible.

DHHR reached an agreement with the DOJ in May 2019 that requires the state to overhaul the existing child welfare system. To facilitate this process, the West Virginia Legislature passed HB 2010 in January

2019, which directed BMS to develop a Specialized Managed Care Plan for Children and Youth (SMCPCY).

The SMCPCY is now known as the Mountain Health Promise Program (MHPP). BMS submitted a 1915c waiver to the Centers for Medicare and Medicaid Services in November 2019 to establish the future MHPP. The waiver was approved in December 2019 for a period of three years and was officially implemented March 1, 2020.

MHPP enrollees are required to obtain medical care through a primary care case management system or specialty physician services arrangements, including mandatory capitated programs. The stated goals of the program are to:

1. Reduce fragmentation and offer a seamless approach to participants' needs;
2. Deliver needed supports and services in the most integrated and cost-effective way possible;
3. Provide a continuum of acute care services; and
4. Implement a comprehensive quality approach across the continuum of care services.[26]

The MHPP is slightly different than traditional Medicaid Managed Care. There is a single Managed Care Organization (MCO) that is responsible for coordinating benefits for all MHPP enrollees. Aetna is the designated MCO for the MHPP population. Aetna is also one of three MCOs available to the traditional Medicaid Managed Care population and has been active in West Virginia since 1996. KEPRO, a specialized health care company, works with Aetna to provide utilization management, approvals, and authorizations for various services. The MHPP is also different than traditional managed care because it makes several additional services available to program participants. Importantly, MHPP enrollees are assigned care managers who are available to coordinate medical care and social services for all program participants. Value-added benefits, such as laptops and GED prep classes, are also available to MHPP enrollees.

The MHPP includes many youth who are also enrolled in the BMS Children with Serious Emotional Disorder (CSED) Waiver program. The CSED is designed to provide additional services to youth ages 3-20 who are in foster care or receiving adoption services. The waiver provides support to reduce residential treatment and institutionalization and keep children with severe serious emotional disorder with their families. Additional services, beyond those covered generally by Medicaid, include:

i. Assistive equipment
ii. Case management
iii. Community transition (ages 18-21)
iv. Mobile response
v. Day habilitation
vi. Supported employment
vii. In-Home family therapy
viii. In-Home family support

ix. Prevocational services
x. Non-Medical transportation
xi. Respite care (in and out-of-home)
xii. Peer parent support
xiii. Specialized therapy [27, 28]

The CSED Waiver amendment request was made in July 2019. The amendment was approved to begin March 1, 2020 and is slated to run for three years. The program is available to all children in the foster care system. West Virginia estimates initial enrollment for 500 members, growing to 2,000 within three years. [29] Membership will likely overlap significantly with the MHPP program.

BMS is required by CMS to conduct an independent assessment of the MHPP. This assessment is intended to evaluate trends in program enrollment, service utilization among participants, contract compliance, and the grievance and appeals processes.

The assessment will rely on both quantitative and qualitative data sources including key informant interviews, reports from Aetna/KEPRO, and Medicaid claims data. BMS has contracted with the West Virginia University Office of Health Affairs to design and implement this assessment.

The MHPP has already made a lasting impact on many youth in West Virginia. The following story provided by MHPP administrators describes just one of the many success stories from the MHPP. Please note that initials have been changed to protect privacy.

AG is a teenager who has struggled with aggressive behavior since a young age. AG was diagnosed as autistic at an early age and has since been diagnosed with conduct disorder as well as attention deficit hyperactivity disorder. AG and his family have been through many losses including the suicide of AG's older brother and a house fire. AG, his brother, and dad all live with dad's parents. AG has a good support system, but with his aggressive behaviors, the family was revolving around his moods and actions. AG was kicked out of school last fall, had charges against him, was placed in DHHR custody, and then sent to a detention facility for 90 days.

AG's social worker applied for the CSED program and AG was approved in September 2020. AG's family chose the two agencies to work with them to provide therapy and resource services. AG has two therapists that are working with him and his family. CD is his therapist who comes twice a week for in-home therapy. MW is the other therapist who comes twice a week to provide in-home family support services. CD and MW have been working together with AG and his family on identifying socially appropriate behaviors. The therapists are also trained in ABA (Applied Behavior Analysis) and have been able to identify why AG behaves like he does.

Prior to AG receiving the CSED services, if he wanted to leave the house, he would go without telling anyone. The family could not get AG to understand that he needed to ask permission and let them know where he wanted to go. This was a constant fight and AG would often throw a fit and become aggressive if he was not allowed to go. The therapists were able to observe AG and identify behaviors that he used prior to leaving the house, as well as why he wanted to leave. The therapists were able to work with AG and his family to recognize the signs and stressors that led to AG leaving the house without asking first.

Now when AG wants to go to the library or for a walk or to visit a neighbor, he comes to the family and asks permission and tells them where he wants to go. The family states that AG has never done this before without a fight. AG's grandfather expressed amazement at the difference in just a few weeks. AG enjoys having the therapists working with him, and he has developed a close relationship with CD and MW. AG also has a respite worker who comes to the house to play games with him. This respite worker is also a therapist and reinforces the goals that are being worked on.

AG and his family have struggled for years to find the help that was needed. AG's grandfather states, "AG's had more help in the last few months than he's had his whole life." AG and the family state, "We couldn't be more pleased with this program." AG and his family are starting to make progress with socially appropriate behaviors and now have hope that wasn't there previously.

Appendix

For additional information about the West Virginia Medicaid program or the content of this manual, please contact BMS at 304-558-1700 or DHHR.BMSsupport@wv.gov

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