West Virginia
Bureau for Medical Services

State Fiscal Year 2015 Annual Report

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

Cynthia Beane, Acting Commissioner
March 2016

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Earl Ray Tomblin
Governor

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The Bureau for Medical Services (BMS) is dedicated to ensuring West Virginians have access to the best health care services possible.

State Fiscal Year (SFY) 2015 was the first full year of serving the Medicaid Health Bridge (expansion) population. The average number of Health Bridge members served was 154,000. The average total number of people who received Medicaid in SFY 2015 was 546,000 West Virginians. Total medical costs were close to $4 billion; 75% ($3.06 billion) federal funds, 17% ($697 million) state general revenue funds and 8% ($344 million) in appropriated and non-appropriated special funds.

SFY 2015 was another year of changes for the Bureau:

- The first West Virginia Health Homes Program started to provide services to people in a six-county area.
- Negotiations between behavioral health providers, BMS, and the Medicaid managed care providers were conducted to transition behavioral health services into Medicaid's Managed Care Program, Mountain Health Trust.
- All three Home and Community Based waivers were up for renewal prior to the end of the fiscal year; thus new applications had to be developed, public comments were solicited, and the applications were submitted to the Centers for Medicare and Medicaid Services.
- Plans were also made to transition the Health Bridge (expansion) population into the Mountain Health Trust Program.
- Medicaid moved to a once a year medical card which will save BMS approximately $2.5 million a year.

Within this report you will find additional information about the West Virginia Medicaid Program and the people we have the honor of serving everyday.

On behalf of the West Virginia Department of Health and Human Resources, it is my pleasure to present the State Fiscal Year 2015 Bureau for Medical Services Annual Report.

Cynthia Beane
Acting Commissioner

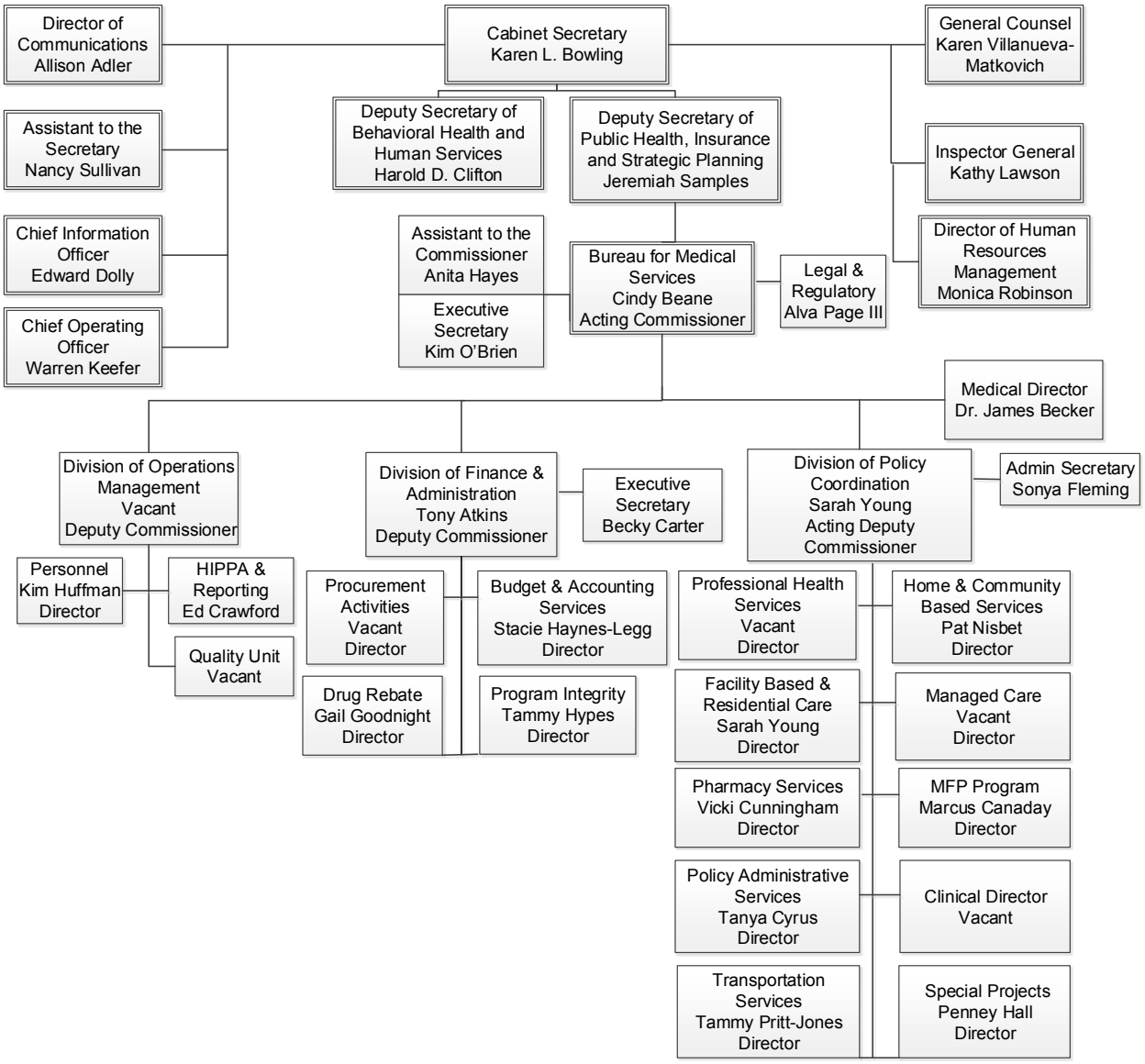
Mission Statement

The Bureau for Medical Services (BMS) is committed to administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that assures access to appropriate, medically-necessary, and quality-driven health care services for all members. BMS will provide these services in a user-friendly manner to providers and members alike and will focus on the future by providing preventive care programs.

Goals for State Fiscal Year (SFY) 2016

- Enhance primary care delivery and coordination in health care infrastructure.
- Work to implement another Health Homes pilot project to address substance abuse among pregnant women.
- Continue to review the Medicaid program to identify cost inefficiencies and work to correct any issues identified.
- Increase Medicaid eligibility groups served by Mountain Health Trust.
- Require Managed Care Organizations to increase preventive care services.
- Optimize the State's Home and Community Based Services.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services



Updated 5/30/2015

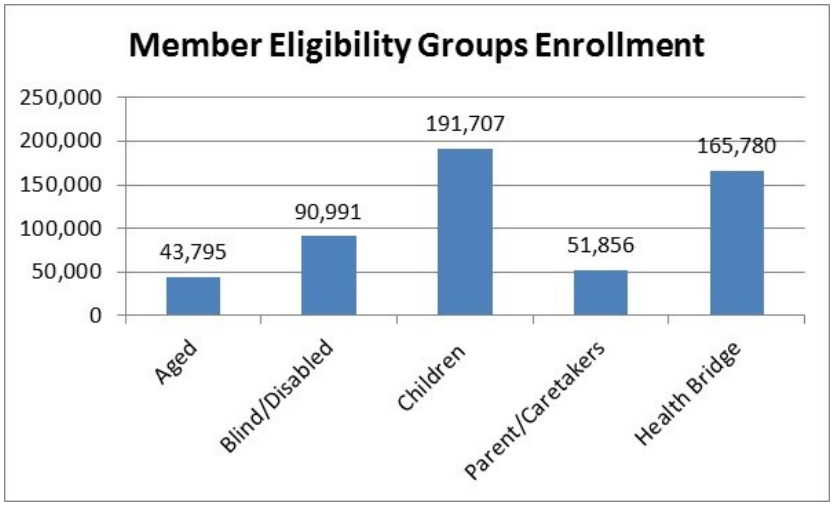
West Virginia Medicaid Program

In 2015, the Medicaid program celebrated its 50th Anniversary. In 1965, the United States Congress passed and President Lyndon B. Johnson signed into law the Medicaid program under Title XIX of the Social Security Act. The Medicaid program was created as a federal-state partnership in which the federal government provides matching grants to states to finance care for children, the aged, blind and/or disabled, and low-income individuals.

The 2010 Affordable Care Act allowed states to expand coverage to individuals ages 19 to 64 who make up to 138% of the Federal Poverty Level (FPL). In 2013, West Virginia expanded its Medicaid population, and these individuals started receiving Medicaid services in January 2014.

West Virginia Medicaid Program Overview

West Virginia Medicaid served as the primary health insurance provider for more than 546,000 West Virginians, or about 30 percent of the total population in SFY 2015. Medicaid provides coverage to pregnant women; children; very low-income families; individuals who are aged, blind, and/or disabled; medically needy populations; and the Health Bridge (expansion) population, which includes individuals between the ages of 19 and 64 who have incomes at or below 138% of the FPL. The chart below shows the number of people enrolled in Medicaid by category:

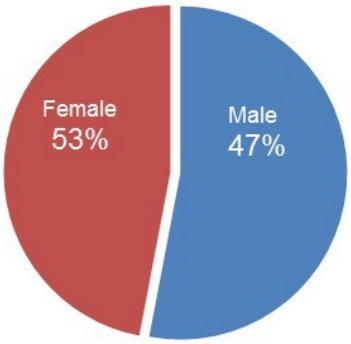


Medicaid Expansion in State Fiscal Year 2015

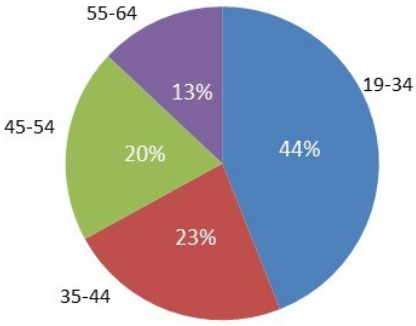
The average Medicaid expansion enrollment in SFY 2015 was 165,000 people.

- 77 percent received at least one Medicaid covered service.
- 23 percent did not receive any Medicaid covered service.
- Approximately 63 percent of expansion members have had some form of income, with 70 percent of those having earned income.
- Data analysis suggests many of these individuals have chronic health problems and mental health needs.

Gender of Expansion Members



Age of Expansion Members



Estimated federal share for the expansion and non-expansion populations for future years:

Calendar Year	Expansion Population Federal Share	Non-expansion population Federal Share
2016	**100 %**	72%
2017	**95 %**	72%*
2018	**94 %**	71%*
2019	**93 %**	71%*
2020	**90 %**	70%*

*These percentages are estimates since the Federal Share is based on economic factors.

***"I want everyone to know that I work and this program is great for the working poor."* —Carla Wallace**

Carla Wallace, a Jackson County, West Virginia resident and single mother, has worked as a hairstylist for 12 years. Being self-employed, she did not have health insurance and suffered from arthritis and lacked clear vision due to a cataract. Although she received treatment at Health Right, a free health clinic in Charleston, West Virginia, the symptoms began to affect her career and she feared she would have to stop working.

When Medicaid expanded, Carla immediately applied for benefits. Once she was approved for Medicaid services, she found a primary care provider who prescribed an anti-inflammatory medicine for her arthritis and she was scheduled for cataract surgery right away.

She is now pain-free and her vision is back to normal. Carla commends the Medicaid expansion because without it she feared her career would have ended and her health would have turned for the worse.

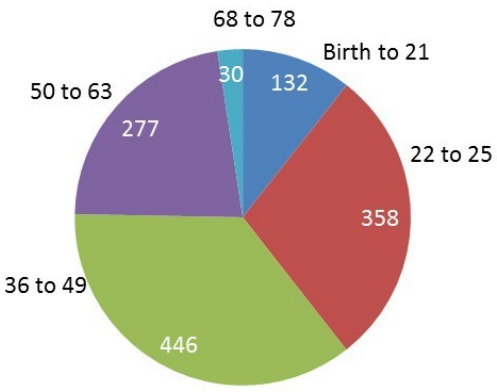
"It's all wonderful! I want everyone to know that I work and this program is great for the working poor. I would be blind and disabled if the expansion never existed," Carla said.

WV Health Homes Pilot Program

The West Virginia Health Homes (HH) pilot program provides individuals in six counties (Kanawha, Putnam, Cabell, Mercer, Raleigh and Wayne counties) an opportunity to have their physical and mental health care needs identified and addressed. The program assists members in receiving the medical, behavioral, and related social services and supports they need in a coordinated manner that recognizes all their needs as individuals and as patients.

The first HHs in West Virginia began enrolling members on July 1, 2014. The focus is on individuals with bipolar disorder and risk of or infected with Hepatitis B or C. Eight providers provided HH services: Cabin Creek Health Strategies, Family Care, FMRS Health System, Marshall University Health, Process Strategies, Prestera Center, Southern Highlands and WV Health Right.

SFY 2015 Health Home Enrollees by Age Group

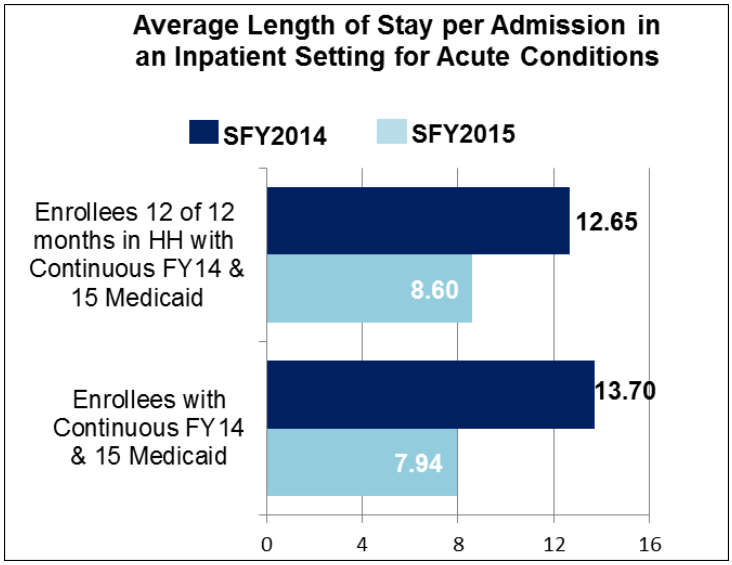


During SFY 2015, a total of 1,243 individuals received HH services; 82 were new Medicaid members who had not received any Medicaid services in FY 2014, and 214 were enrolled for 12 months of the program.

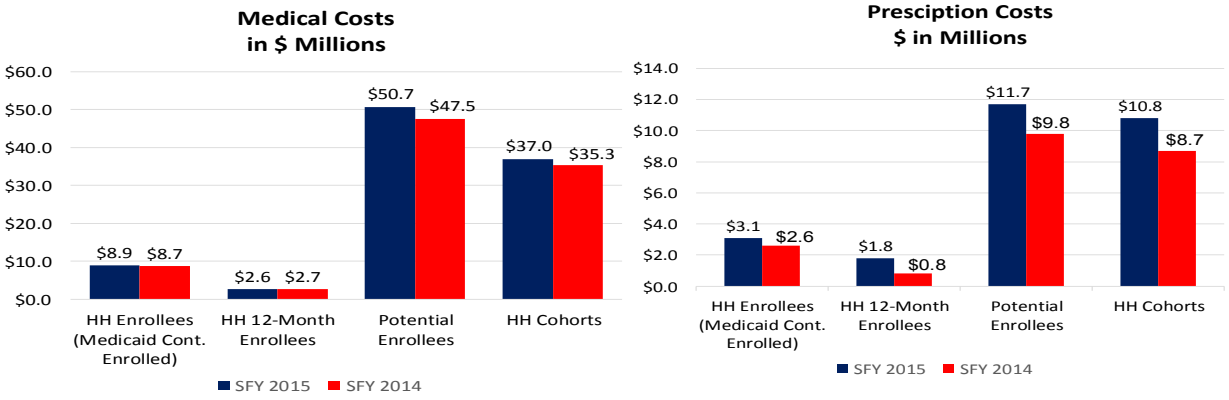
The following results were seen:

- 118 HH members were reported as hepatitis positive; 161 were identified at high risk for hepatitis.
- 732 (59%) HH members smoked and/or used tobacco; 473 received smoking and tobacco use cessation.
- 100% of the enrollees age 12 and older were screened for depression; 79% were clinically depressed at the time of the screening.
- SFY 2015 emergency department costs were reduced by $17,639 for HH members.

The table below shows a 42% reduction in the average length of stay in a hospital for all HH members who had Medicaid coverage in both SFY 2014 and SFY 2015. Those members who were enrolled in a HH for the entire year saw a decrease of 32%. The decrease can be attributed to better discharge planning.



The medical costs in SFY 2015 for HH members remained about the same as in SFY 2014. Prescription costs for HH members increased in SFY 2015. This increase in cost can be attributed to the high cost of treating hepatitis and the increase in drugs overall. However, when compared to potential HH members (Medicaid members in the same six-county area with a bipolar diagnosis) and HH cohorts (six counties in the northern part of West Virginia), the cost savings are significant as shown in the charts below:



*Health Homes enrollees are limited to individuals continuously enrolled in Medicaid during SFY 2014 and SFY 2015. 12-month enrollees are additionally limited to individuals enrolled with a Health Home for the full SFY 2015 (initial program period).

"We need to offer more programs like this in our communities."—Jonathan Rubenstein

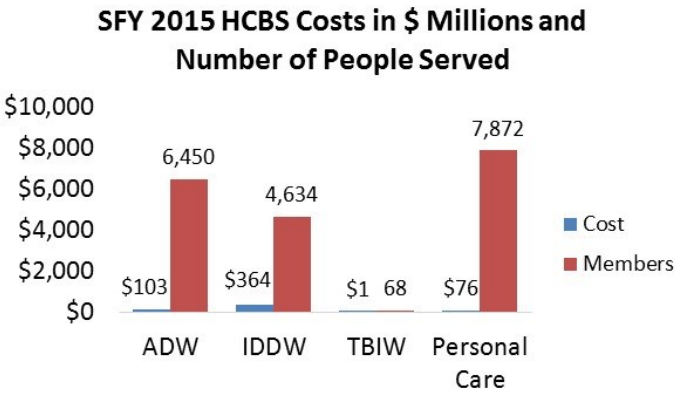
Jonathan Rubenstein is a 35 year old recovering drug addict with bipolar depression. His undiagnosed bipolar condition led to his drug addiction resulting in a very dangerous and unhealthy lifestyle. Jonathan tried many recovery programs only to fail because he was missing the support that was needed to deal with his bipolar condition. Due to all his broken promises, he lost the support of his family and friends.

As a current patient at one of the Health Homes providers, Health Right, he was introduced to the Bureau for Medical Services' new Health Homes program by his psychologist, Brenda Parker. Jonathan now has a team that provides the support he has always needed to recover and stay healthy. His Health Homes provider sets up all of his doctor appointments as well as additional supports so that he can remain healthy. He hopes to reconnect with his family and daughter.

"Brenda Parker is my best friend, she makes sure that I have rides to appointments, she checks on me and makes it easier for me to get in and out of appointments. I am so lucky to be alive and clean. I always avoided responsibilities but the Health Homes program helps me feel healthier and ready to face those responsibilities," Jonathan said. "We need to offer more programs like this in our communities."

Home and Community Based Services

Home and Community Based Services (HCBS) allow individuals to remain in their own homes and communities with the supports and services they need. BMS has 10 HCBS which include a mixture of optional (waiver services) and mandatory services and one grant program. Below is a brief overview of each of these services.



1. **Aged and Disabled Waiver (ADW):** ADW services are for individuals 18 years of age and older who need nursing home level of care but choose to stay in their own home. During SFY 2015, 6,450 individuals received services, and 280 were awaiting services at the end of the fiscal year.

2. Intellectual/Developmental Disabilities (I/DD) Waiver: I/DD Waiver services are for individuals who have a diagnosis of intellectual and/or developmental disabilities and who have been determined to need intermediate care facility level of care. During fiscal year 2015, the I/DD program served 4,634 individuals, with 1,116 individuals awaiting services at the end of the fiscal year.

3. Traumatic Brain Injury (TBI) Waiver: TBI Waiver services are provided to individuals at least 22 years of age with a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in the need for a nursing facility level of care. During fiscal year 2015, 68 individuals received TBI Waiver services.

4. Personal Care Services: These services are medically-necessary activities or tasks ordered by a physician, which enable individuals to meet their needs in their homes rather than as a hospital inpatient or nursing home resident. In SFY 2015, 7,872 individuals received these services.

5. Hospice: Hospice services provide a continuum of home and inpatient care for terminally ill patients and families and/or significant others during the final stages of life and bereavement. In SFY 2015, 428 individuals received services at a cost of $26.4 million.

6. Home Health: These services are medically-necessary services such as skilled nursing; home health aides; physical, speech, occupational and other therapeutic services; and nutrition services on a part-time or intermittent basis. Home Health services were provided to 7,820 at a cost of $55.3 million in SFY 2015.

7. Private Duty Nursing: These services are provided to members under 21 years of age who are in need of face-to-face skilled nursing that is more individualized and continuous than the nursing that is available under the Home Health benefit or routinely provided in hospital or nursing facilities. In SFY 2015, 250 individuals received services at a cost of $7.6 million.

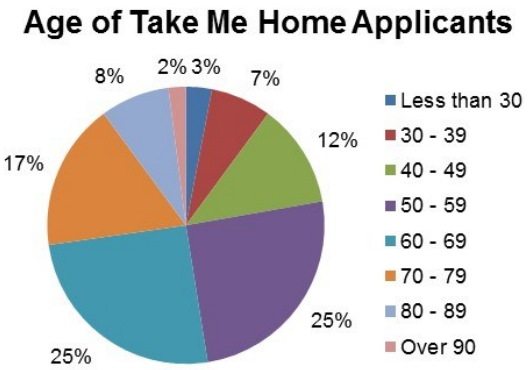
8. Behavioral Health Services: Services include behavioral health clinic and rehabilitation services, psychiatric services, psychological services, and targeted case management provided in the community. During SFY 2015, 88,965 members received these services at a cost of $107.2 million.

9. Children with Disabilities Community Services: This program provides services to children with severe disabilities and is an alternative to institutionalization. In 2015, 81 children were served.

10. Take Me Home, West Virginia: This federally-funded Money Follows the Person Rebalancing Demonstration Grant program assists qualifying individuals with disabilities and/or the elderly move from a long-term care facility to a home in the community. *Take Me Home* participants receive supports from existing HCBS programs or the Supported Housing program operated by the Bureau for Behavioral Health and Health Facilities as well as transition services to make their return home smoother.

In SFY 2015, the *Take Me Home* staff and Council submitted a sustainability plan to the Centers for Medicare and Medicaid Services which was approved. The plan outlines how the program will be maintained once the grant period is completed.

	SFY 2013*	SFY 2014	SFY 2015
Number of applicants	122	157	150
Number found eligible for Take Me Home	110	156	137
Number found ineligible for Take Me Home	3	5	8
Number of Transitions Back to the Community	6	47	59
Pending applications	9	5	0



*These numbers represent the start of the program in February 2013 to June 30, 2013.

***"I would recommend this program because it was a 100% success for me." —*Charlina Sizemore**

Charlina "Charlie" Sizemore of Mount Hope was an independent and energetic 49 year old nursing student completing her externship at a hospital when a work accident ended her dream of becoming a Registered Nurse. The accident resulted in a broken back, a concussion, loss of memory and a two year stay in a nursing home.

"It's very hard to be the youngest patient in a nursing home and have your independence taken from you," said Charlie.

An employee of the nursing home told her about *Take Me Home, West Virginia,* a Money Follows the Person program, and assisted her in contacting transition navigator Samuel Ball. Samuel assisted her in finding and furnishing an accessible home and even provided her with groceries when she first transitioned from the nursing home to her new home. The program also provided her with the durable medical equipment she needed in her new home such as a walker and hospital bed.

She has a personal attendant who comes to her home during the week to assist her in performing the tasks she is not yet able to perform on her own. In addition, her sister and the community periodically check in on her to ensure she is okay.

"I would recommend this program because it was a 100% success for me; it is a great program for people like me who was once an independent person, but had suffered an injury," said Charlie.

Non-Emergency Medical Transportation

In October 2014, Medical Transportation Management (MTM) began operations as the broker for Non-Emergency Medical Transportation (NEMT) services for Medicaid members, excluding individuals who need stretcher services (transportation by ambulance). The Bureau for Medical Services saved approximately $3.4 million in NEMT services during SFY 2015; $1.9 million of the savings came from the contract with MTM which included a rebate of anything over their annual pre-tax profit of 7.5%. The remaining estimated $1.5 million came from cost savings due to a streamlined process of ensuring the NEMT service was used properly.

MTM provides statewide brokering services that include, but are not limited to:

- Screening to determine the appropriate mode of transport;
- Verifying member eligibility;
- Verifying the transportation request is for a covered service with an enrolled provider;
- Scheduling the trip with an enrolled transportation provider;
- Verifying the vehicles and drivers are properly licensed; and
- Making provider payments.

From October 2014 to June 20, 2015, MTM:

- Received 413,000 calls;
- Scheduled 475,000 trips;
- Denied 23,000 trips;
- Had a call abandonment rate of 3.26%;
- Had an average time of 34 seconds to answer a call; and
- Had an average time of six minutes to handle a call.

BMS Partners with Department of Corrections and Regional Jail Authority

The Bureau for Medical Services started working with the Division of Corrections (DoC) and the Regional Jail Authority (RJA) on January 1, 2014, by providing Medicaid coverage to inmates who were hospitalized for more than 24 hours. This collaboration results in a reduction to the amount of state dollars spent on inmate care, since Medicaid gets a federal match.

In SFY 2015, there were:

- 231 claims processed; and
- $1.1 million in paid claims for in-patient hospital stays.

Phases two and three of this collaboration target enrollment of individuals who are substance abuse users, those on probation and parole and those who have been discharged from prison or jail to ensure a smooth transition to community based services.

The West Virginia Division of Justice and Community Services has contracted with the Center for Health Care Strategies to support a multi-stakeholder effort to connect newly Medicaid eligible individuals with criminal justice involvement to health care coverage and services. BMS is an active partner in this effort.

BMS Issues Yearly Medicaid Cards

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) shifted from issuing monthly medical cards to a yearly card in April 2015. The estimated cost savings for BMS is $2.5 million, which includes savings from the cost of the paper, printing, and postage.

The medical cards retained much of their original look except there is no expiration date or managed care organization listed on the card. DHHR provided medical providers a couple of ways in which to verify coverage of a member including:

- Checking on-line through the Medicaid Management Information System (MMIS) provider portal; or
- Calling MMIS and using the voice recognition system.

In addition, members are able to get a duplicate card by:

- Contacting their case worker at their local DHHR office;
- Contacting the DHHR customer service center; or
- Going to the MMIS member portal and printing out a Letter of Creditable Coverage which is valid for the day it is printed.

Managed Care

Mountain Health Trust (MHT) is West Virginia's Medicaid Managed Care program. The Bureau for Medical Services (BMS) initiated a risk-based managed care program for certain groups of Medicaid recipients in September 1996. In SFY 2015, the Bureau had contracts with four managed care organizations (MCOs) for the provision of medically-necessary services currently provided by the State, with the exception of behavioral health, long-term care, and non-emergency medical transportation services.

The MCOs under contract with BMS are Coventry Health Care of West Virginia, The Health Plan of the Upper Ohio Valley, UNICARE, and West Virginia Family Health Plan. As of July 1, 2015, Mountain Health Trust had a total enrollment of 209,958 members.

	Under age 2	2 - 14 years	15 - 19 years	20 - 29 years	30 years and over	Total Enrollment
Coventry	7,523	41,935	10,435	6,379	8,722	74,994
The Health Plan	3,877	19,066	5,294	3,109	4,336	35,622
UNICARE	8,409	52,637	13,063	6,843	9,316	90,268
WV Family Health	1,065	2,104	1,297	1,440	2,168	9,074
Total	20,874	116,682	30,089	17,771	24,542	209,958

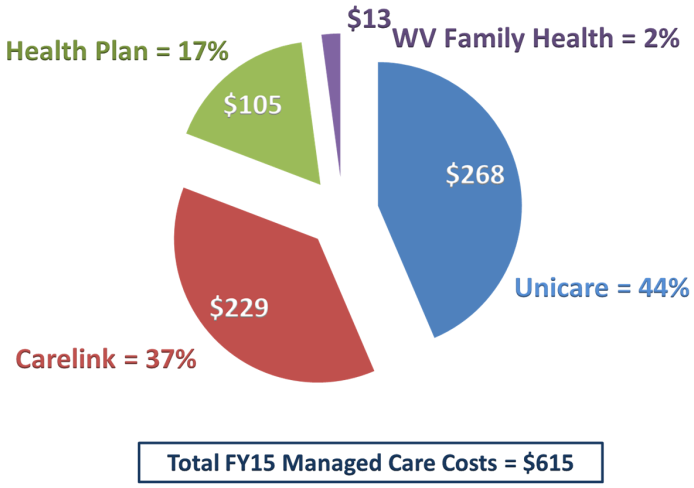
Presented below is an analysis of West Virginia's MCOs performance in three areas according to the National Committee for Quality Assurance (NCQA). The WV Family Health Plan is not included in these ratings since they did not start providing services until mid-year.

Rating	Plan Name	Consumer Satisfaction	Prevention	Treatment
3.5	Coventry Health Care	3.5	2.5	2.5
3.5	Health Plan of the	3.5	3.0	2.5
3.0	UNICARE Health Plan	2.0	3.0	2.5

- 1.0 to 2.0 = lower performance
- 2.5 to 3.5 = medium performance
- 4.0 to 5.0 = higher performance

According to NCQA, most Medicare and Medicaid plans were rated in the middle (2.5 to 3.5) across the nation.

Presented below is the Managed Care costs in SFY 2015 in millions by plan.



In SFY 2015, the State strengthened its oversight of the Mountain Health Trust program by requiring the MCOs to meet or exceed five performance measures in order to obtain their full capitation payment. The five measures were:

- Well-child visits in the third, fourth, fifth, and sixth years of life;
- Adolescent well-care visits;
- Immunizations for adolescents;
- Medication management for people with asthma (75% compliance) - ages 5 to 64; and
- Postpartum care.

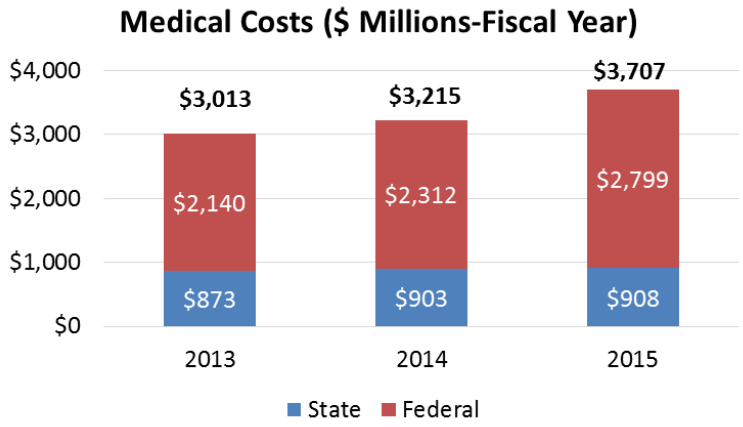
The State saved approximately $26 million in SFY 2015 due to managed care and expects savings to increase as more Medicaid populations are added to managed care in the coming years.

Financial Overview

Medicaid is a jointly funded federal and state program. The federal share of funding is based on the Federal Medical Assistance Percentage (FMAP), which is updated each federal fiscal year (October 1 to September 30).

The FMAP rate for the state's expansion population is 100 percent for its first three years (2014 to 2016), and then decreases in each subsequent year until reaching 90 percent in 2020.

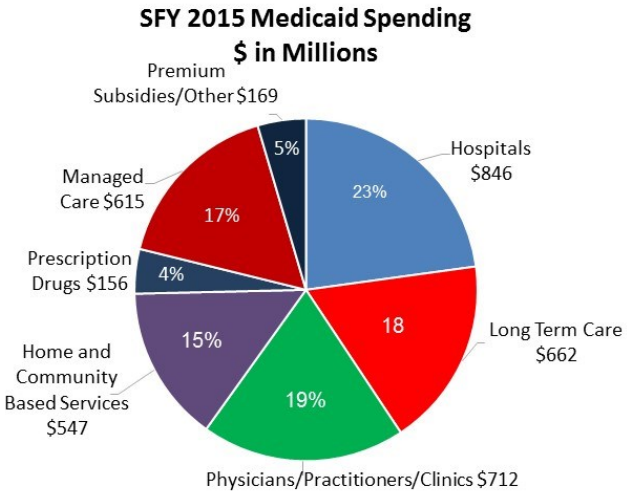
The chart below compares the last three state fiscal years' medical costs and the division of those costs between state and federal dollars. SFY 2015 was the first full year of Medicaid expansion and services were reimbursed at 100%, which explains the increase in the federal share.



The chart below compares the average cost per member over the last three state fiscal years. The decrease in cost can be explained by Medicaid's diligent fiscal stewardship and increased oversight of the performance of the managed care organizations. Another factor is that starting in January of 2014 and all of 2015, the Health Bridge population was added and those members on average were less costly than the traditional Medicaid population.

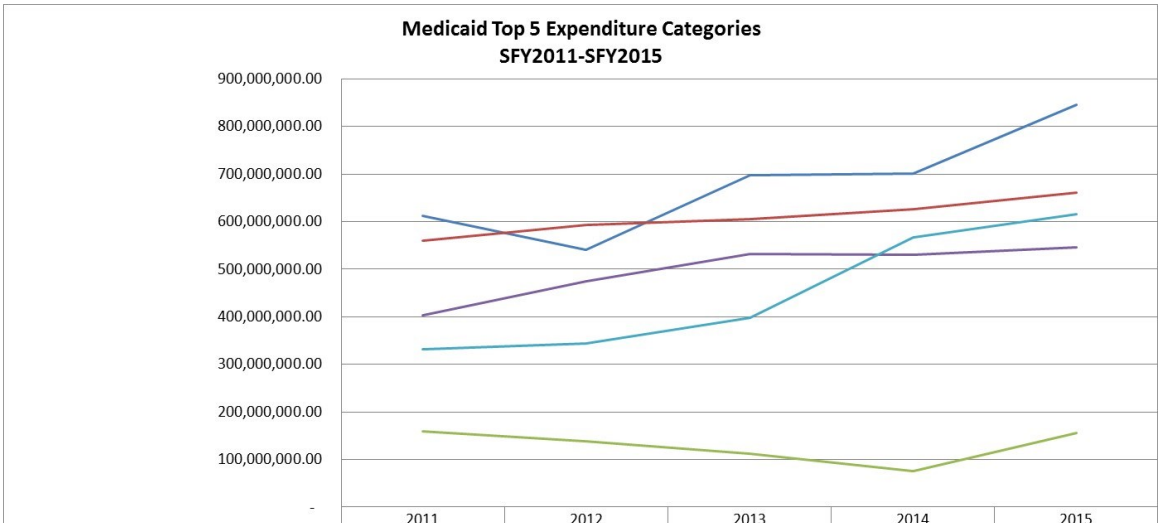
Medicaid Spending by Program

During SFY 2015, more than 544,000 West Virginians received Medicaid services for a total cost of $3.707 billion. Approximately 210,000 of them received services through the state's managed care program. The chart below outlines the total Medicaid costs in SFY 2015 by category:



Expenditure Trends

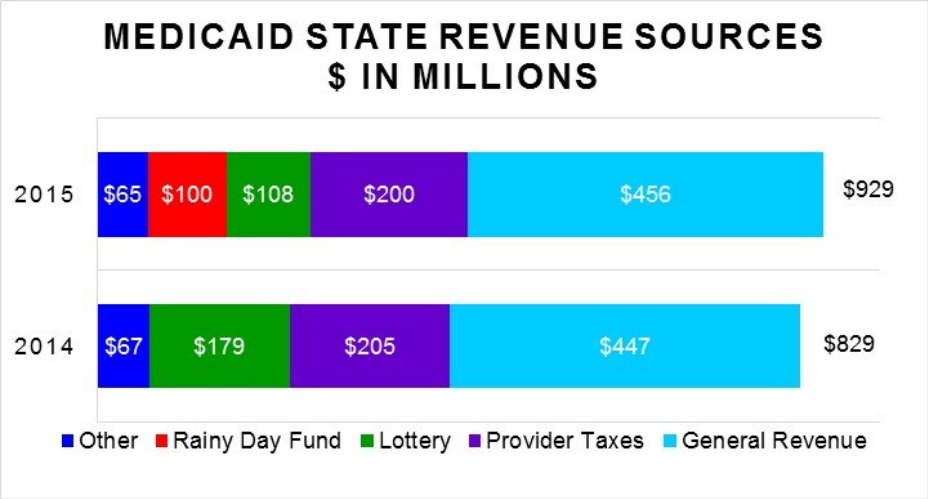
Expenditures in the top five categories have increased over the five year period. SFY 2015 saw major increases in hospital services and in prescription drug services primarily due to the Medicaid expansion population being in the fee-for-service program. It is anticipated that in SFY 2016 there will be a decline in these two categories since the expansion population was moved into managed care starting in July 2015. Long term care (nursing homes), managed care, and home and community based services remained fairly stable from SFY 2014 to SFY 2015.

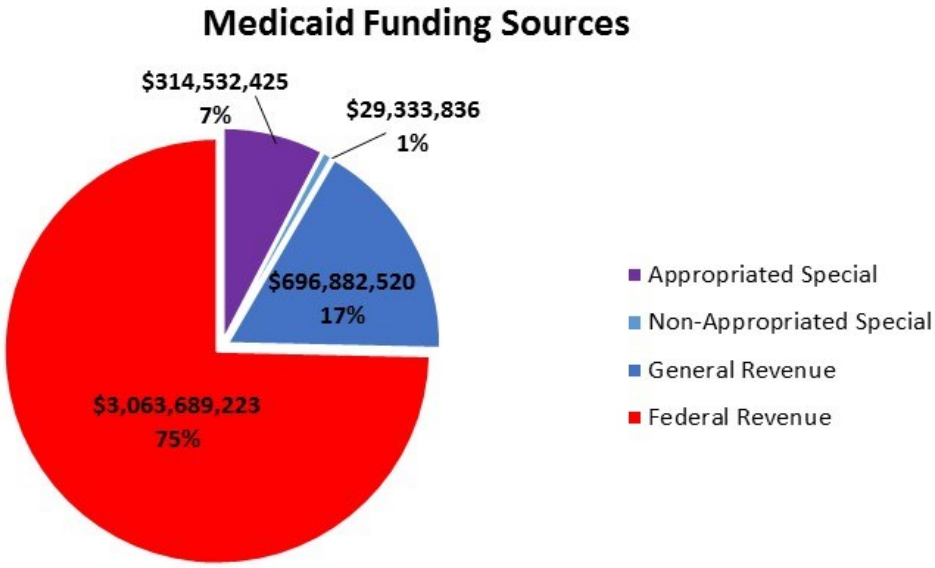


	2011	2012	2013	2014	2015
Hospital Services (including Mental Health Facilities)	612,615,184.92	541,536,545.61	697,052,964.11	700,524,584.62	846,326,570.06
Long Term Care	559,806,725.91	592,939,500.85	605,705,200.57	626,850,088.38	661,802,100.59
Prescribed Drugs (net of rebates)	159,639,210.77	137,518,938.27	112,090,523.48	75,598,743.46	156,165,487.11
Home and Community Based Services	402,530,181.66	475,360,587.95	532,014,280.98	530,760,734.62	546,367,313.46
Managed Care Organizations	331,340,463.12	343,161,264.43	397,197,343.00	566,153,479.00	615,339,739.00

Medicaid Revenue Sources

Medicaid funding comes from many different sources. In West Virginia, the Medicaid budget makes up approximately 29 percent of the state budget. The charts below show the state revenue sources for the Medicaid budget:





Pharmacy Services and Drug Rebates

All Medicaid eligibility groups receive prescription drug coverage. Like the private sector, BMS maintains a preferred drug list and requires prior authorization for high-cost, high-risk drugs. Members are asked to pay a co-payment on certain drugs. The Medicaid program is eligible for drug manufacturer rebates.

During SFY 2015, Medicaid spent close to $447 million for prescription drugs and received rebates exceeding $209 million from federal and supplemental programs and managed care organizations, lowering the overall cost of prescription drugs to approximately $238 million, a savings of almost 53%. Below is a chart of the pharmacy costs and drug rebates for SFY 2015:

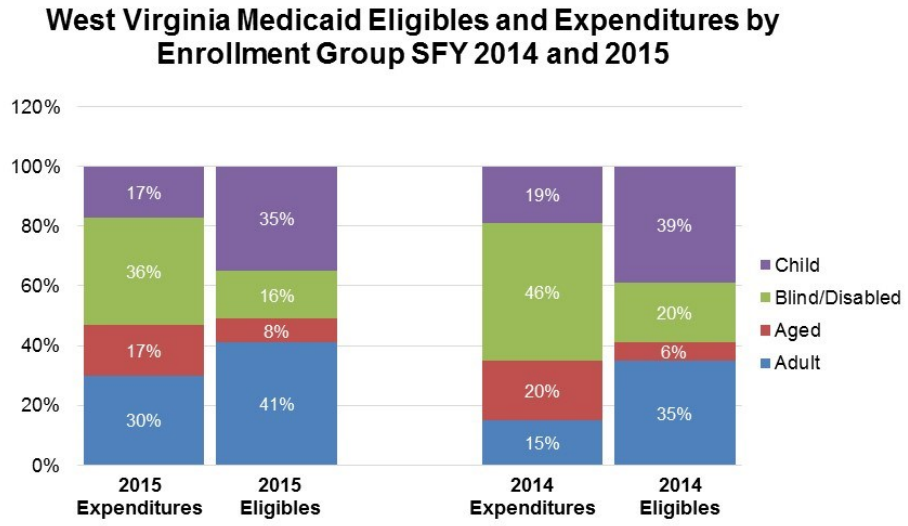
Prescribed Drugs	$446,971,859
Drug Rebate Offset - National Agreement	($225,015,92)
Drug Rebate Offset - State Sidebar Agreement	($15,905,952)
Drug Rebate Offset - MCO National	($45,732,577)
Drug Rebate Offset - MCO State Sidebar Agreement	($4,151,916)

Medicaid Spending by Member Category

As the chart below illustrates, adults and children (under age 18) accounted for 76 percent of the Medicaid enrollment in SFY 2015, a two percent increase over SFY 2015. However, these two groups accounted for 47 percent of total Medicaid expenditures in SFY 2015, a 12 percent increase over the previous year.

The number of blind/disabled and aged individuals accounted for 24 percent of Medicaid members in SFY 2015, a two percent decrease over the previous year. Nevertheless, they accounted for 53 percent of the expenditures in SFY 2015, a 13 percent decrease from the previous year.

It is important to note that SFY 2015 is the first full year the Medicaid expansion population received services and accounts for the percentage of increase in the adult category.



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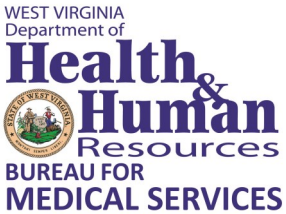

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