



West Virginia Medicaid Mountain Health Trust Annual Report

**State Fiscal Year 2015
(July 2014 – June 2015)**

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MOUNTAIN HEALTH TRUST PROGRAM OVERVIEW

Mountain Health Trust (MHT) is West Virginia's Medicaid managed care program, administered by the Bureau for Medical Services (BMS). The program aims to improve access to high-quality health care for Medicaid beneficiaries by emphasizing the effective organization, financing, and delivery of primary health care services. MHT currently serves low-income children and families, and children with special health care needs. BMS contracts with managed care organizations (MCOs) and physicians to provide health services and medical homes for each Medicaid member. The medical home allows members to receive better quality care by having a continuous source of coordinated care accessible to the member. The concept of the medical home is central to the MHT program and is universally offered to members regardless of the member's conditions.

In the MHT program, eligible Medicaid beneficiaries living across West Virginia may select an MCO, which is a health plan that coordinates services for members, and are asked to choose a primary care provider (PCP). For most beneficiaries, the PCP serves as the main source of care and as a facilitator for accessing specialty care. The types of providers who may act as PCPs include pediatricians, general and family practice physicians, internal medicine physicians, obstetricians/gynecologists, nurse practitioners, and certified nurse midwives. Each MCO has a defined network of providers that is monitored by BMS to ensure that MHT beneficiaries have adequate access to PCPs and specialists.

In two of the 55 counties, members may instead select a PCP from the Physician Assured Access System (PAAS), West Virginia's primary care case management program. Under PAAS, PCPs coordinate care for members. In return, they receive reimbursement on a fee-for-service basis along with a monthly case management fee. There are approximately three thousand Medicaid recipients enrolled in this program. The PAAS program will be phased out in SFY16 as more MCOs expand their coverage areas.

This report focuses primarily on the MCO program, which has established a multi-dimensional partnership between BMS, the federal government, members, providers, and the MCOs that participate in the program. The program ensures all beneficiaries receive personalized, patient-centered care. Goals of the MCO program include:

- Providing a medical home to every member,
- Increasing use of primary and preventive care,
- Improving compliance with immunization schedules and well-child visits,
- Improving birth outcomes,
- Enhancing member satisfaction with the program, and
- Containing the escalating costs of Medicaid.

BMS actively monitors program outcomes to ensure that the goals are met and to identify areas for improvement. BMS tracks member satisfaction by requiring monthly and quarterly reporting from the MCOs on key metrics as well as the use of nationally-recognized monitoring methods such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey. Program outcomes such as member satisfaction are discussed in greater depth below.

"I would like to thank you for all the help Mountain Health Trust has given me. I'm raising two boys on my own and without your help I don't know if I would have been here today to raise them. So thank you with all my heart."

MHT Medicaid member

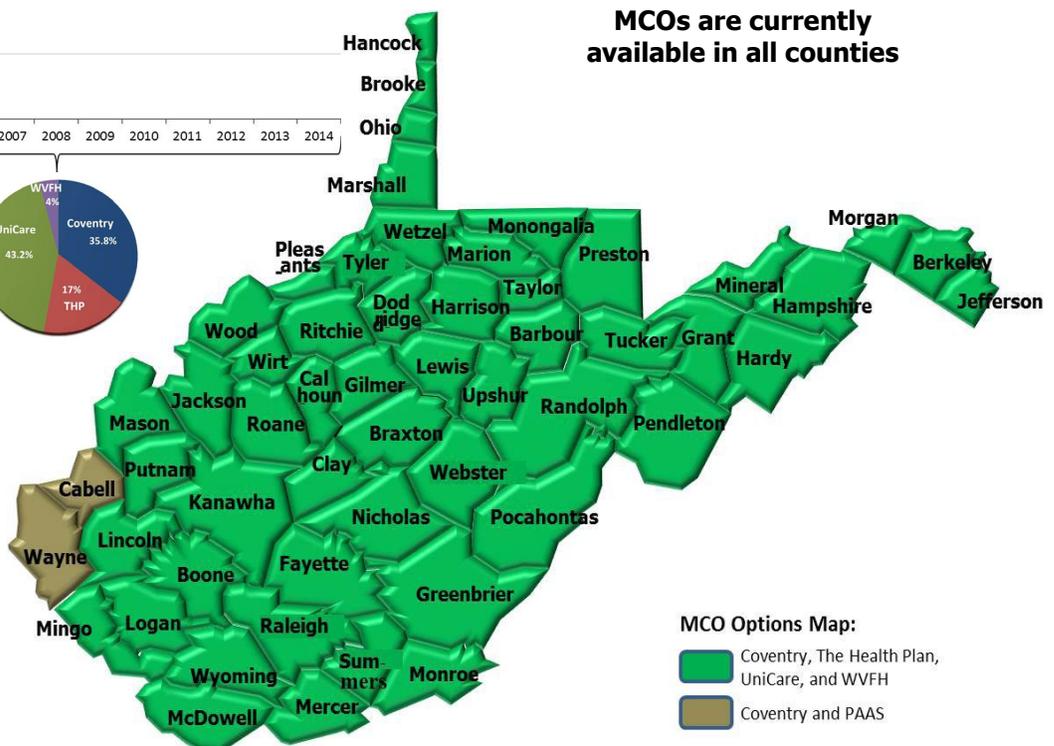
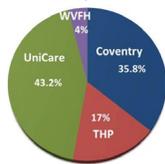
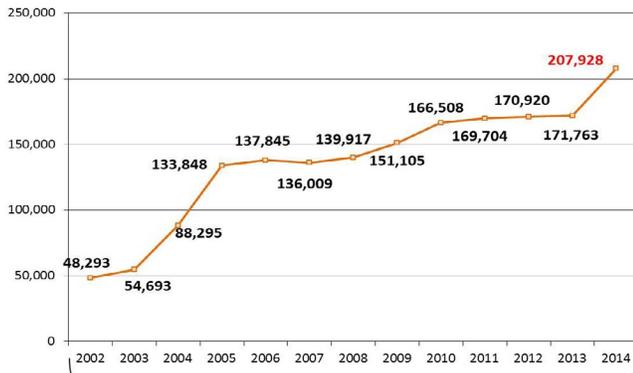
ENROLLMENT IN MCOs IS GROWING

As of June 2015, Medicaid beneficiaries in 53 of West Virginia's 55 counties were required to enroll in a contracted MCO and beneficiaries in the remaining two counties were offered a choice between an MCO and PAAS.¹ 207,928 Medicaid members were enrolled in MCOs at the end of State Fiscal Year (SFY) 2015, and approximately 3,300 additional members were enrolled in the PAAS program. MCO enrollment has more than tripled since 2002.

¹ In September 2015, beneficiaries in all counties except Wayne and Cabell counties were given a choice of an additional MCO. PAAS is a choice for beneficiaries in Cabell and Wayne counties.

Currently, the state contracts with four health plans to provide services to beneficiaries in its MCO programs, two of which are for-profit (Coventry Health Care of West Virginia and UniCare), and one of which is not-for-profit (Health Plan of the Upper Ohio Valley). The fourth, West Virginia Family Health (WVFH) is a provided-sponsored network. In 2014, an additional MCO, West Virginia Family Health (WVFH), was approved to participate in the MHT program. WVFH began serving members on September 1, 2014 in 53 of 55 counties in the state. The Health Plan (THP) and Coventry Health Care of West Virginia (Coventry), have been under contract since the inception of the MCO program in 1996, and UniCare of West Virginia, began enrolling members in November 2003. The MCOs have continued to expand their service areas and enroll new members in the program, and are present in every county in West Virginia. They are committed to expanding further to maximize member choice of MCOs. THP and UniCare are working with BMS and CMS to expand managed care services into Cabell, and Wayne counties.

More than 207,928 members were enrolled in MCOs in June 2015; approximately eighty percent of the members were enrolled with either UniCare or Coventry



PROGRAM SERVICES

The majority of MCO members are children; 80percent are 19 years old or younger. Because the MCOs serve a large number of children and adolescents, the program emphasizes screening and preventive care to keep them healthy. MCOs ensure that all services, both clinical and non-clinical, are accessible to members.

What Services are Covered by the MCO Program?

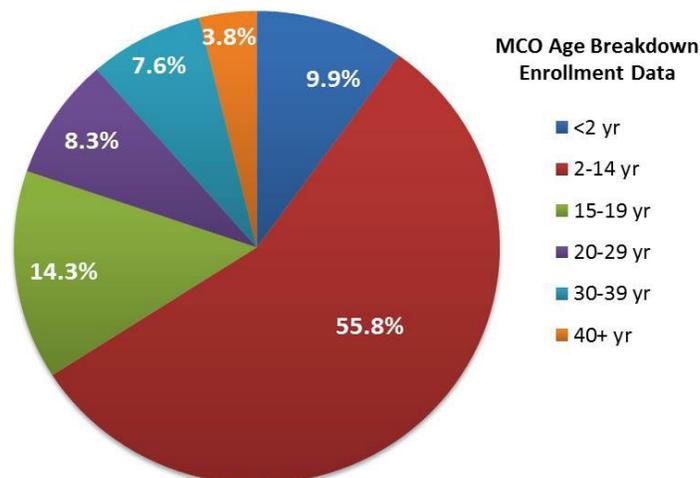
BMS is required to provide certain services to members in order to qualify for federal matching funds (“mandatory services”). In addition, BMS has chosen to provide additional services (“optional services”) to provide broader care to members. and optional Medicaid services that are covered

- Ambulatory surgical center services
- Cardiac rehabilitation
- Children with Special Health Care Needs services
- Clinic services
- Chiropractic Services
- Dental services (children)
- Diabetes education
- Durable medical equipment
- Emergency dental services (adults)
- Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Children < 21)
- Family planning services and supplies
- Home health care services
- Hospice Care services
- Hospital services, inpatient
- Hospital services, outpatient
- Inpatient rehabilitation

Some services are not provided by MCOs, such as behavioral health services, nursing homes, and non-emergency transportation. These services are available through regular Medicaid (also known as fee-for-service). Behavioral health services will be included as covered services by the MCOs in SFY16.

As of January 1, 2014, children’s preventive dental and orthodontic services were added to the list of covered services.

80% of MCO members are 19 years old or younger



The following services include both mandatory by MCOs under the Mountain Health Trust:

- Laboratory and x-ray services, non-hospital
- Nurse practitioner services
- Occupational therapy
- Primary and Preventative Care Visits
- Pharmacy services
- Physical therapy
- Physician services
- Prosthetic devices
- Podiatry services
- Prescription drugs
- Private duty nursing
- Pulmonary rehabilitation
- Rural health clinic services (including federally qualified health centers)
- Speech therapy
- Tobacco cessation programs
- Transportation, emergency
- Vision services



COST SAVINGS

The MCO program provides quality care while generating cost savings for West Virginia. The program has created savings by slowing growth in the use and cost of medical services found in traditional fee-for-service (FFS) Medicaid. In addition to medical savings, there are administrative efficiencies. In SFY 2014, the MCO program achieved savings of approximately \$46 million

in combined federal and state funds, compared to the costs of covering the same population through FFS. Increased savings have been recognized due to services added to managed care in recent years such as pharmacy and dental, the latter of which was added to managed care effective January 1, 2014. That change is fully reflected in the SFY 2015 data used for analysis.

SFY 2015 Estimated MHT Program Total Savings

	Fee-for-Service (FFS)*	MHT
Member Months	2,445,814	2,445,814
Average Number of Members Per Month	203,818	203,818
Medical/Capitation per Member per Month	\$254.42	\$241.28
Total Medical/Capitation Spending	\$622,259,405	\$590,119,589
State Administrative Costs	\$23,468,962	\$9,113,259
Total Spending	\$645,728,367	\$599,232,848
SFY 2014 Total Savings for MHT		\$46,495,519
Percent Savings over FFS		7.2%

*FFS refers to the estimated cost of serving the MHT program in a FFS setting rather than managed care setting.

DISEASE & CARE MANAGEMENT

All Medicaid MCOs have embraced care management, developing programs that help members with diabetes, asthma, and other complicated conditions to lead healthier lives. Each of the conditions identified by the MCOs is prevalent in West Virginia (diabetes, cardiac and pulmonary conditions) or is of particular risk to Medicaid beneficiaries (asthma and prenatal care). Each disease management program is designed specifically for the Medicaid population and encompasses health education, member outreach, case management, and physician clinical support. MCOs work to identify members with chronic or high-risk conditions, and educate them about appropriate use of medications and methods of self-management. The MCOs notify the PCPs of patients with chronic conditions to encourage PCP participation in care management. Where applicable, the programs also incorporate lifestyle influences.

Coventry has an enhanced case management program that offers special assistance to members with serious, long term medical needs and promotes quality of care to reduce the likelihood of extended, more costly health care. The program provides a method for ensuring that health care for specific, eligible members is improved while medical costs are managed to the appropriate level. The program focuses on the continuum of care, addresses the health care needs of a limited number of members, and stresses medically appropriate care and member involvement in the health care process. Face to face visits are com-

pleted with members by the case manager to further assist in the plan of care. Coventry utilizes a biopsychosocial model of Case Management in which all aspects of the member's healthcare are addressed with a primary case manager ensuring complete and individualized care plans.

UniCare's Disease Management (DM) programs offer a holistic, member-centric care management model that provide interventions tailored to unique healthcare needs of its members. Through a monthly continuous case finding process, DM identifies members with low to moderate levels of risk who have chronic conditions that fall within eleven structured DM programs, eight of which have been NCQA-accredited since 2006, including but not limited to Bipolar Disorder, Hypertension, and Asthma. Moderate risk members who are actively engaged with a nurse receive telephonic coaching to include comprehensive health risk assessment (HRA), collaborative care planning, and follow-up. The comprehensive HRA identifies needs across the continuum of care including physical health, behavioral health, social and environmental factors, and lifestyle health risks.

THP has a care management program that is diagnosis driven and staffed by nurses. The program takes a holistic approach to management where members are identified and managed based on the presence of chronic conditions and does not delineate management by the types of conditions present. The level of management is determined based on the severity of the member's condition and includes face-to-face interactions when members need or want it.

West Virginia Health Statistics in 2013

Health Condition	Percent of West Virginia's Population*	Percent of National Population*	West Virginia's National Ranking
Any Cardiovascular Disease (Myocardial Infarction, Angina/Coronary Heart Disease)	13.7% (95% CI: 12.8-14.7)	8.6% (95% CI: 8.4-8.7)	Highest
Hypertension	41.0% (95% CI: 39.5-42.4)	32.5% (95% CI: 32.3-32.8)	2nd Highest
Obesity	35.1% (95% CI: 33.6-36.6)	28.3% (95% CI: 28.0-28.5)	Highest
Diabetes	13% (95% CI: 12.1-14.0)	10.3% (95% CI: 10.1-10.4)	4th Highest

West Virginia Bureau for Public Health, Health Statistics Center as part of the national Behavioral Risk Factor Surveillance System.
*The percentages and numbers of persons estimated to be at risk are subject to sampling error.

West Virginia Family Health's (WVFH) hallmark disease management program, Gateway to Lifestyle ManagementSM (GTLM), focuses on improving the health outcomes and well-being of members with certain chronic conditions including Asthma; Chronic Obstructive Pulmonary Disease (COPD); Cardiac disease; and Diabetes. GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. Chronic disease management for the WVFH members supports the physician's plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and member empowerment strategies. Interventions are based on member's risk status and needs and can include a telephonic holistic assessment which evaluates six domains of need including behavioral, environmental, economic, medical, social and spiritual. Ongoing care coordination with care plan development is offered as warranted. Members are provided with tools to assist in the management of their chronic condition such as 7-day pillboxes to help with medication adherence. GTLM continually evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

The following is an overview of the programs with specific examples of some of the MCO approaches.

Diabetes

All four MCOs offer care management to diabetic members. Goals of these programs include improving glycemic control, optimizing functional capacity, and reducing risk factors. In addition, the MCOs use a number of intervention strategies to specifically target the needs of diabetics. These strategies include distributing diabetes screening reminders, outreach phone calls, case management of high-risk members, and the provision of diabetes clinical tools. For example, Coventry offers telephonic disease management in which members are contacted by a health coach or a registered nurse

for telephonic education. As part of the program, members receive free testing for diabetes-related health indicators and participate in a series of classes with Certified Diabetes Educators about managing their health. The test results are also sent to the member's PCP for review for any needed treatment change. A Coventry pharmacist also reviews the member's medications and works with the member and primary care physician to develop an appropriate treatment plan. Coventry also has a diabetes collaborative program where face to face diabetes education classes are completed. When classes are complete and A1C is drawn, members are eligible for a \$25 dollar gift card. THP has three nurses who are certified diabetes educators on staff and who do the telephonic program and face to face individual diabetes education as well as group sessions, including the Journey for Control[®] program. In addition, THP partnered with Med Express urgent care centers to provide alternative sources of care for members with diabetes. UniCare offers eligible diabetic members an incentive for taking an active part in managing his or her diabetes. Eligible members who completed recommended diabetic laboratory testing (HbA1c, LDL, and Urine microalbumin) by the end of the year were eligible to receive a \$25 gift card. An additional \$25 incentive was offered to eligible diabetic

Know Your Blood Sugar Patterns

When you see the low and high trends on your blood sugar graphs, some important questions - such as the ones below - may come to mind. Your answers to them can help you better know how to keep your blood sugar in a normal range.

The Foods I Eat

Is my portion size correct? _____

What do I eat each day? _____

Do I choose low-fat, low-sugar, low-salt and high-fiber foods? _____

Physical Activity

Do I get enough physical activity? _____

Have I been very active? Or have I stopped any usual activities? _____

My Medicines

Do I take the dose the doctor ordered? _____

Do I take my medicines at the right times? _____

Do I store my insulin as it should be? Is my insulin out-of-date? _____

Do I take a new prescription or over-the-counter (OTC) medicine? _____

Does my doctor know about all the medicines I take? _____

Illness, Infection and Stress

Do I feel healthy? _____

Do I have an infection? _____

Do I have added stress? _____

Talk with Your Health Care Team

When you have questions about changes in your blood sugar level, talk with your diabetes care team. They include your doctor, diabetes educator, dietitian and/or pharmacist.

SOURCE: MayoClinic.com, www.mayoclinic.com

members who completed a diabetic retinal eye examination in the same timeframe.

WVFH invites members with diabetes into the Gateway to Lifestyle Management Program and provides an informative brochure containing tips for diabetes management and encourages members to contact a registered nurse Care Coordinator if they need assistance managing their diabetes. Members are eligible to receive incentives for taking an active role in managing their diabetes. Eligible members can receive a \$25 gift card for completing the recommended HbA1c test and another incentive for obtaining their annual qualifying eye examination. WVFH offers members' access to the Care4life Diabetes Texting Program through their partnership with Voxiva. This six-month program of diabetes education is focused on Type 2 diabetes. This texting program allows members to better manage their diabetes through frequent, brief text messaging with the option of medication and appointment reminders if desired.

All MCOs are required to participate in a diabetes collaborative performance improvement project (PIP) to increase the number of members whose diabetes is controlled. As a collaborative PIP, UniCare worked with Coventry and THP to develop and distribute an informative, educational letter to providers regarding the importance of following evidence-based guidelines. The educational letter provided current clinical guidelines recommended for diabetes and website addresses for each of the Mountain Health Trust (MHT) Managed Care Organizations (MCOs).

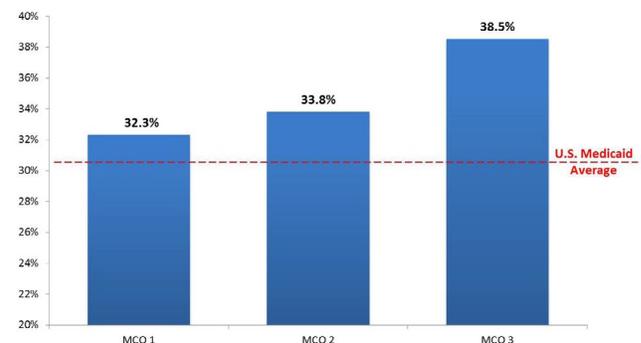
Asthma

Approximately 13.6% of West Virginia adults have been diagnosed with asthma and 9.0% of West Virginia adults currently have asthma, according to the 2013 Behavioral Health Risk Survey conducted by the West Virginia Bureau for Public Health, Health Statistics Center. To improve the health of Medicaid beneficiaries, all four MCOs offer disease management to members with asthma. The MCOs aim to reduce emergency department visits, decrease rescue medication usage, and improve members' asthma self-management skills. Coventry uses

an Asthma Condition Management Program that capitalizes on the provider-patient relationship. Targeted providers are given an asthma tool kit with education modules to assist them with enhancing the member's understanding of their disease and ways in which to mitigate the symptoms associated with the disease. The member is given an asthma action plan to help them deal with times of disease exacerbation and have an opportunity for a monetary incentive for completing the training program. Members with asthma are also provided disease management through targeted educational mailings and telephonic case management.

THP's Wellness and Health Promotion Outreach Department calls members that have been identified as having asthma. Members complete a telephonic assessment. At the completion of the assessment, members are sent an educational packet that includes a voucher and an action plan for members to take to their physician. Upon THP's receipt of the completed voucher, a Registered Nurse calls the member and/or guardian for a more in-depth assessment and one on one education. The member is then sent a peak flow meter, spacer and additional educational materials. Approximately one to two weeks after the assessment has been completed, a follow up phone call is made to the member to verify receipt of the mailing, provide an opportunity for questions, reinforce education, and encourage an appointment with their physician. Members are encouraged to take their peak flow meter, spacer, and action plan to their next appointment. Any members identified with asthma through THP

All three MCOs exceeded the national Medicaid averages for the percent of members who complied with asthma medications 75% of the time



outreach phone calls or review processes are forwarded to the Quality Improvement Department for inclusion in the program.

UniCare offers health education classes to members and parents of members with asthma to provide education on different asthma triggers and peak flow meters.

The Gateway To Lifestyle Management program offered by WVFH provides an information brochure to members with tips for asthma management and encourages members to contact a registered nurse Care Coordinator if they need assistance managing their asthma. WVFH also provides targeted outreach education to members with asthma based on seasonality. For example, members received education during the spring months related to allergies and medication adherence to help control symptoms and decrease asthma flares. Care Coordinators send members color coded stickers which help differentiate between their rescue and long term control inhalers. Both adult and pediatric members receiving telephonic case management are provided with Asthma Action Plans and are encouraged to take them to their physician for completion. Educational information related to asthma is also contained on the WVFH website, in member newsletters and the Member Handbook.

Prenatal Care

With 9.2 percent of West Virginia babies being born with a low birth weight in 2014 as compared to 8.0 percent nationally,² and Medicaid funding more than half of all births in the state,³ prenatal care is a primary concern for the Medicaid program. Due to a number of factors, low birth weight is more common among Medicaid beneficiaries, and has meaningful implications for the long term health of the child. The best way to reduce these occurrences is through improved prenatal care. All four MCOs offer prenatal care management to improve pregnancy outcomes and reduce the costs associated with pregnancy complications.

Coventry strives to improve birth outcomes through member education, facilitating care coordination, addressing substance abuse issues

by working with providers and community resources, and promoting prevention. Breast feeding counseling and support is available with a certified Lactation Counselor on staff. Members identified as high risk are enrolled in our condition management program for High Risk Obstetrics. This program focuses on application of “best practices” such as the promotion of 17 alpha-hydroxypregesterone (17P) and Makena to assist in the prevention of pre-term labor. Mothers-to-be identified with Substance Use Disorder are referred to their Neonatal Abstinence Syndrome program for case management. The member is engaged during the prenatal phase and continues with the mom and baby through the first year of the baby’s life, regardless of the infant’s eligibility. Mothers enrolled in the NAS program at the time of Delivery receive a Pack and Play. Case Management staff are embedded in two high risk clinics to further enhance the identification and education of high risk members in a face to face environment.

The Health Plan focuses on reducing NICU admissions and reducing all costs associated with preterm birth and other complications of pregnancy. This is accomplished by providing perinatal education including outreach calls, a telephonic high risk program, mailings of March of Dimes educational materials, promotion of safe healthy behaviors, and enhancement of the management of maternity care for women identified at high risk for premature labor and delivery. Outcomes monitoring is continuous and reported regularly. The report includes rate of preterm deliveries, rate of low birth weight deliveries, rate of cesarean deliveries both primary and repeat, rate of elective deliveries <39 weeks both vaginal and cesarean, NICU days/1000 births, NICU length of stay, rate of smoking at enrollment and at delivery, rate of prenatal care first trimester, rate of check-up after delivery, antenatal steroids prior to preterm deliveries and perinatal depression.

² This number is from the America’s Health Rankings Report for 2014 published by the United Health Foundation. This statistic can be found at <http://www.americashealthrankings.org/WV>.

³ This statistic is from the Kaiser Family Foundation’s State Health Facts website. This statistic can be found at <http://www.statehealthfacts.org/>.

Ongoing monitoring by a registered nurse ensures timely intervention in the event of a change in risk status.

UniCare's *Taking Care of Baby and Me™* program is a proactive case management and care coordination program for mothers during the prenatal and postpartum period and their newborns. The program offers:

- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

Experienced case managers work with members and providers to establish a care plan for the highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, home visitor programs, breastfeeding support and counseling.

The three plans included in the SFY15 HEDIS measurement period exceeded the national benchmark of 82 percent of pregnant members receiving timely prenatal care by at least five percentage points.

WVFH's MOM Matters® perinatal program improves maternal outcomes with a focus on both timely and ongoing prenatal care, post-partum care, maternal smoking and substance abuse as well as reducing psychosocial barriers to care. The MOM Matters® program is a two pronged approach, using nonclinical Navigators and licensed clinical staff. The Navigators contact new and/or low-risk members, and assist with scheduling appointments, obtaining needed interpreter services, making referrals and linkages to services and coordinating ancillary services. The Navigator works with the member to complete a maternity assessment and identify physical and behavioral health needs, gaps in preventive health screens, and other needs with

which the member would like assistance. The Navigator refers expectant members to a Care Coordinator at any point as needed or requested. The clinical Care Coordinator works with those members who are high risk to provide ongoing coaching and support throughout the pregnancy. The clinical Care Coordinator provides ongoing coaching for those members who are high risk, and develop and implement an individualized plan of care to support them throughout the pregnancy. Members are encouraged to utilize programs such as WIC and Text4baby to provide support through the prenatal and postpartum period. Members are eligible to earn incentives for receiving care throughout the pregnancy, post-partum period and well visits after the baby is born.

Cardiac-Related Chronic Conditions

All MCOs offer disease management programs that work with members that have cardiac-related chronic conditions; these programs are designed to slow disease progression and modify cardiovascular risk factors. Goals of the programs include reducing the frequency of hospitalization, improving quality of life, and reversing or stabilizing symptoms. The MCOs emphasize pharmacologic compliance, needs assessment, and provider and member communication to reduce the risks of future complications. To enhance the normal care management efforts, the MCOs use targeted educational mailings and telephonic intervention for high-risk members. In addition, evidence-based guidelines are distributed regularly and are recommended for use by physicians to medically manage patients with chronic heart failure. In 2015, two of the MCO's HEDIS scores for the percent of members with high blood pressure who had their blood pressure controlled (decreased), a significant factor in reducing the likelihood of a cardiac-related event. BMS worked to identify best practices across the plans to promote improvements among all the plans in 2015.

WVFH invites members with heart disease into the Gateway to Lifestyle Management Program and provides information on heart health and encourages members to contact a registered

nurse Care Coordinator if they need assistance managing their cardiac condition. In addition to mailed education and telephonic case management, members with heart failure can receive a scale to help them monitor for weight gains that may signal a potential flare of their heart failure.

“I can’t thank you enough for all your help. If it wasn’t for your compassion and hard work, I’m not sure where my family would be today.”

MHT Medicaid member

Chronic Obstructive Pulmonary Disease

All four MCOs offer disease management programs for members with chronic obstructive pulmonary disease (COPD). The programs are designed to slow the progression or stabilize the symptoms of COPD, as well as reduce the frequency of hospitalization. In addition to normal management services, Coventry provides ongoing, comprehensive care that increases the member’s awareness of his or her condition and the value of treatment and self-management. THP educates members about the disease process, recognition of symptoms, and medication compliance. In addition, nurses make phone calls at periodic intervals determined by the severity of the member’s symptoms and primary attention

is given to the application of appropriate pharmaceutical therapies including the use of ace inhibitors and beta blockers, enhancement of self-management skills, and systematic surveillance of those with symptomatic heart failure to prevent hospitalization. Enrolled members

also receive (as needed): home scales, smoking cessation interventions, referrals for nutritional education, referrals for home oxygen/respiratory therapy, pulmonary rehabilitation, and immunizations. The MCOs demonstrated a weighted average of 65.3 percent and 67.4 percent of members receiving system corticosteroids and a bronchodilator respectively, which are pharmacy-related therapy for managing COPD episodes in 2015.

WVFH provides both telephonic and mailed education to members living with COPD. The education focuses on reducing exacerbations, medication adherence, smoking cessation, the importance of good nutrition and lifestyle management. Registered nurse Care Coordinators provide ongoing assessment, coaching, goal setting, and care plan development.



HEALTH PLAN OUTREACH AND EDUCATION

MCOs Offer Extensive Health Education Programs

MCOs offer a variety of educational and preventive programs, in addition to disease management. The goal of these programs is to educate members about various health topics and conditions and help them understand how to use the health care system more effectively. The health education and preventive programs encourage members to be proactive about their own health and the health of their families. Below are some examples of the MCOs activities to target specific health issues and conditions:

Preventive Care

Coventry member newsletter, *The Bear Facts*, includes important information for members such as immunization reminders and the importance of screenings such as Pap tests and mammograms. Additionally, Coventry conducts monthly outreach events through participation in health fairs or read aloud events.

Coventry's EPSDT program notifies families when children are due for wellness visits or when they may have missed a wellness visit. The program also includes schedule notifications for vaccinations and lead screenings. Coventry sends targeted reminders to members needing cervical and breast cancer screenings, as well as members who fall within Centers for Disease Control and Prevention recommendations for flu and pneumonia immunizations. In addition, Coventry's outreach department has begun combining the outreach planning and scheduling with the quality scores of their program. HEDIS results for several key indicators are calculated by geographical region. Outreach events such as community baby showers, health fairs, health presentations in schools, etc. are scheduled and materials included are driven by the quality scores determined through the HEDIS results. Monthly mailings are sent to primary care physicians with their "gaps in care" listing. This mailing identifies specific members in their practice who are either due/ or late for a preventive service visit such as a well-child visit or adolescent well care visit. Member

incentives are available for successful completion of preventive care visits including well-child, and adolescent well-child encounters.

THP offers an array of preventive health interventions to help decrease the progression of illness and chronic disease. THP provides education to members and performs outreach through its website, community, and school-based promotion programs. Its initiatives include: offering personal health risk assessments for adult members; providing educational materials, monthly wellness information, interactive health tools, and preventive health guidelines by request from the website; and conducting student outreach on topics such as tobacco use, drug and alcohol awareness, bullying, safety, first aid, sun safety, overall wellness/components of health, understanding test results, healthy choices, and diabetes prevention. Adult members are also invited to attend any of several community flu clinics and health fairs at various locations throughout the state.

In addition, THP employs health and wellness representatives, who conduct outreach calls to members to complete medical assessments and educate members on the importance of preventive health. The MCO's goal is to use direct contact to motivate members to obtain missing preventive services. Primary care physicians are sent a copy of items discussed so that they can follow up with members.

WVFH utilizes a multipronged approach to preventive health including mailed education and targeted telephonic outreach campaigns. In addition to education and care gap reminders, telephonic outreach also consists of assistance with appointment scheduling and transportation as well as appointment reminders as needed. Preventive health reminders are an integral part of every member contact at WVFH. Staff have access to care gap reminders through an internal application and reminders for the whole family can be provided to the parent or guardian. Through the WVFH Member Portal members can complete a Health Risk Assessment and receive a personal health report based on their responses which they can share with their physician. The WVFH web-

site contains wellness brochures on topics such as dental care, pediatric vision, exercise and activity, substance abuse, medication safety and smoking cessation. Member incentives are available for receiving well care from infants to adults.

UniCare uses a strategy of mailings and direct outreach (e.g., plan representatives calling members) to inform members about a variety of preventive health measures including lead screening, childhood immunizations, and cervical and breast cancer screenings. To improve prenatal care, UniCare has partners with community-based organizations throughout the state to launch baby showers and expand outreach efforts. The objectives of the program are to bring maternal and child health education to high-risk Medicaid populations in West Virginia and partner with key community-based organizations to expand outreach. UniCare offers a range of health education

services in a variety of formats to meet the needs of members throughout the state including referral to Weight Watchers, Text 4 Baby, and tobacco quit lines. Through a program of presentations, crafts and games, parents and children attending this community event receive health education on topics relevant to child health: e.g., physical activity, nutrition, oral health, and weight control.

Additionally, UniCare has extended its incentive program for compliance with breast cancer screenings and diabetic care management to include member incentives for postpartum and well infant visits in an effort to improve health-related behaviors.

Nutrition, Physical Activity, and Weight

CoventryCares partners with state and local charitable food distribution programs to provide needed dietary resources and related health information to the State’s most vulnerable population. Coventry provides financial support to the partner groups who distribute the food products, and supplies the recipients with valuable health information related specifically to their regional need. Regional information is determined through the CoventryCares member encounter data information, and typically includes topics and related resources associated with well-child health visits, immunizations, and prenatal care.

THP promotes the maintenance and achievement of a healthy lifestyle by engaging members in wellness and promotion activities such as education, physical activity, and health screenings. THP provides school- and employer-based health and wellness training modules. On-site clinics and wellness activities are also held at schools. THP also developed a healthy snack program focusing on healthy choices and encouraged physical activity through the use of a nationally recognized jump rope team.

UniCare offers eligible members assistance with weight management issues through Weight Watchers. The UniCare website of-

Sample Newborn Education Material from Unicare



Bringing your baby home checklist

Are you ready to bring your baby home?
Use this checklist to help you prepare:

- Car seat (rear-facing infant seat)
- Your baby’s primary care provider or pediatrician:
 - Name of provider: _____
 - Office phone number: _____
 - After-hours phone number: _____
- Insurance (private or Medicaid): _____
- Women, Infants and Children (WIC): _____
- Early Childhood Intervention (ECI): _____
- Child care provider: _____
Phone number: _____

Discharge plans

1. Medication your baby goes home with:

2. Equipment your baby goes home with:

3. A copy of your baby’s hospital shot record-



fers a variety of educational and informational articles pertaining to weight management, healthy eating, remaining active, and healthy lifestyles.

WVFH provides information related to exercise and activity through its member website. Members can complete a health assessment that allows them to identify lifestyle behaviors they want to modify and provides information on those modifications. Lifestyle management with a focus on activity and good nutrition is an integral part of case and disease management activities.

Tobacco Cessation

THP offers two free tobacco cessation programs: “Freedom from Smoking” and “Not-On-Tobacco” which are targeted at adults and adolescents, respectively. The programs are provided by employees of THP who have been trained as American Lung Association facilitators.

UniCare offers tobacco cessation assistance to members through resources that include a telephonic Quit Line for ongoing support and a Quit Kit. The Quit Kit includes information on coping skills for fighting the urge to smoke, strategies for success after a relapse, and other valuable tools. The UniCare website offers additional information and education regarding smoking cessation, pregnancy and smoking, avoiding secondhand smoke, and more. As a value added benefit, members can receive a Safelink mobile phone that provides complimentary access to care with providers, the Quit Line, MedCall (the 24-hour nurse advice line), and UniCare customer service.

CoventryCares offers telephonic smoking cessation interventions with a tobacco cessation facilitator on staff, the Quit Line, and a 24 hour nurse advice line. All members that are identified with tobacco use are sent educational materials and resources for tobacco cessation. Strategic mailings target members seeking to become tobacco free.

WVFH promotes the use of the West Virginia Quit Line for smoking cessation activities. Educational material is also provided on the WVFH website and through the Member Portal. Smoking assessment and cessation education is provided through all telephonic interactions with members. The Quit Line is provided on chronic

disease management literature to assist members in becoming tobacco free.

MCOs Adopt Emergency Department Performance Improvement Projects

In addition to the MCOs’ established outreach and education, the plans are expected to develop initiatives to achieve improvements in areas that have been identified as critical by BMS. During 2015, all four plans participated in collaborative performance improvement projects to reduce inappropriate emergency department utilization related to childhood asthma and improve the number of diabetic members who have controlled hemoglobin levels.

Inappropriate Emergency Department (ED) utilization diverts critical care resources from those who truly require them, creates barriers to continuity of care, and unnecessarily escalates health-care costs. By promoting medical homes and PCP relationships, BMS aims to reduce inappropriate ED utilization and its corresponding health care costs. Previously, BMS required the MHT MCOs to target specific populations or geographic areas with high ED utilization. However, in 2014, BMS required all of the MCOs to participate in an ED utilization collaborative focused on reducing the number of ED visits by members between the ages of 2 and 20 years. BMS has tasked the state’s External Quality Review Organization (EQRO),

The MCO conduct efforts to reduce improper ED utilization beyond case management efforts:

- The MCOs sent a collaborative letter to providers to inform them of the focus on asthma-related ED visits and provide resources on appropriate treatment of asthma.
- Coventry provided an incentive to members with asthma who complete regular health care visits to PCPs and use maintenance medications.
- THP makes phone calls to members with asthma to complete a health assessment and provide education on managing their disease.
- UniCare also has nurse coaches who perform outreach to members to help them adhere to plans of care.

Delmarva Foundation, with coordinating the collaborative, in which the MCOs work collectively with BMS and Delmarva to determine best practices for decreasing unnecessary ED utilization and work to implement the identified practices across the MCOs. In addition, all four MCOs will have their own initiatives to decrease unnecessary ED utilization. The MCOs made their baseline measurements this year based on calendar year 2014 data, which is the most recent available. They will continue to track these rates in the next year and alter their interventions accordingly.

In 2015, WVFH began implementing their ED diversion programs in West Virginia. WVFH applies a proprietary algorithm through their gDNASM analytics platform that identifies members who have a combination of high-risk indicators such as frequent admissions, frequent ED visits, gaps in care, and also assesses where the majority of care is being served either by multiple specialists or a single source. In addition, social determinants of health are also analyzed to understand barriers to care such as access to food, transportation, and other barriers that could prevent a member from seeking care with their PCP. These analytics help drive care management activities by focusing on the most at-risk members. Once members are identified, WVFH performs targeted outreach and other care management strategies to engage members in proactively managing their health and improving outcomes. WVFH will have baseline data for 2015 in January 2016 and will seek to further improve ED utilization throughout 2016.

WVFH also partners with network Primary Care Physicians and incentivizes PCPs to close gaps in care for adolescent immunizations and well child visits. Incentive strategies to improve access to primary care are a key driver in reducing inappropriate ED visits. WVFH deployed several outreach campaigns to members with gaps in care for Adolescent Immunizations and Well Child Visits, offering appointment scheduling

and transportation assistance. WVFH will report outcomes for these measures in June 2016.

As mentioned, diabetes is a primary concern for the health of the state and the Medicaid population, in particular. BMS has identified a need for targeted efforts in this area and, in response, asked the EQRO to also coordinate an effort with the MCOs to reduce the number of diabetic members who have uncontrolled hemoglobin levels. This collaborative also made baseline measurements based on calendar year 2014 data. Results on the success of the program will be assessed in coming years.

Coventry continues internal programs to improve the number of adolescents attending well-care visits. This year Coventry improved their rate for the third year in a row to 50.6%, achieving their aim to increase the rate of visits by five percent over the coming year.

THP also continued their concentration on childhood obesity. The MCO works with providers to encourage the accurate reporting of Body Mass Index (BMI) to ensure that children who are obese can be identified and targeted for nutritional and physical activity counseling. Since the start of the program in 2008, THP has seen significant improvements in the percentage of members with evidence of BMI documentation and nutritional counseling.

UniCare is working to improve the percentage of children who receive their immunizations by their second birthday. Since the MCO began the project, they have increased the rate of children receiving immunizations to 67.1%, though they made significant improvements in their rates they did not reach their goal of meeting the national Medicaid average. UniCare will continue working to implement programs to increase the number of children complying with the immunization schedule.

QUALITY, ACCESS, AND TIMELINESS OF CARE

BMS is committed to assessing and improving the quality of services that the MCOs offer to members enrolled in the Mountain Health Trust program. BMS uses a three-pronged strategy for assessing and improving managed care, which consists of prospective, concurrent, and retrospective activities. This multi-faceted strategy enables BMS to quickly identify potential problems and work with the necessary parties to resolve them. For example, BMS reviews quarterly data from the MCOs to monitor indicators such as PCP and emergency room (ER) utilization, PCP-to-enrollee ratios, and experiences with member and provider services.

As part of the effort to monitor and improve quality, BMS requires the MCOs to send a consumer satisfaction survey annually to a sample of Medicaid recipients in West Virginia. Over 2015, BMS reviewed the results of the 2014 member survey, based on the nationally-accepted Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey. Areas of focus included access to care, availability of needed services, communication with providers and the health plans, and satisfaction with providers and health plans. The MCO survey results were compared to the national Medicaid averages.

High Satisfaction Reported for Children

As reported in previous years, parents of children enrolled in the managed care program are very satisfied with their child's MCO, doctors, and care. Over eighty four percent of parents of children enrolled in MCOs gave their MCO or health plan an overall rating of eight or higher (using a zero to 10 scale, where zero is the "worst possible" and 10 is the "best possible"). In addition to their satisfaction with their programs overall, parents reported high satisfaction in a number of areas.

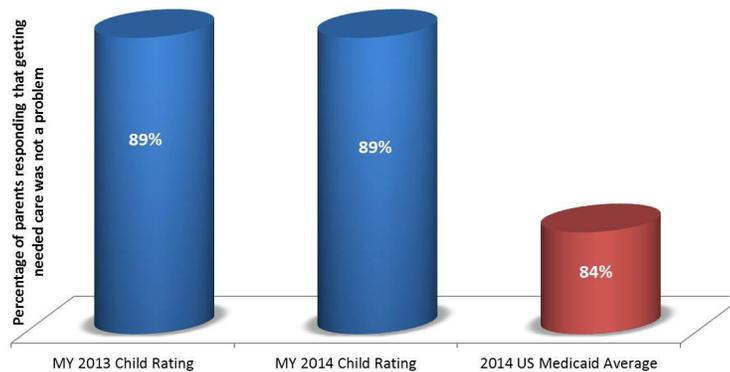
A vital element of health care is the ability of members to access care when needed. Ninety-four percent of parents of children

enrolled in an MCO reported that it was "always" or "usually" easy for their child to quickly get the care, tests, or treatment he or she needed. This exceeds the national Medicaid average.

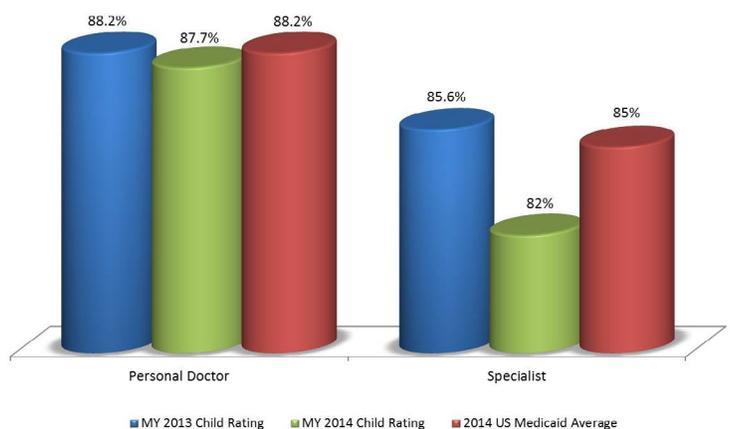
The following tables reflect quality scores using measurement year (MY). The measurement year is the period from which data was collected to calculate the measure rates. Rates for MY 2014 reflect MCO performance between Jan. 1, 2014 and Dec. 31, 2015.

For several other key indicators in the child survey, including satisfaction and communication

The MHT program exceeded the national Medicaid average for the percent of parents who indicated it was "usually" or "always" easy to get the care, tests, or treatment their child needed



Parents were satisfied with their children's personal doctor & specialists



with a member's personal doctor and satisfaction with a member's most commonly seen specialist, ratings for the MCOs met or exceeded the national Medicaid averages.

High Satisfaction Reported for Adults

Similar to parents of enrolled children, the majority of adults in the MCOs and PAAS program were satisfied with their MCO, doctors, and care overall. Enrolled adults rated their personal doctors highly with seventy-five percent of adult survey respondents gave their personal doctor a rating of 8 or above (on a scale of 0-10), which is close to the national average. Access to specialists is expected to be slightly lower considering that West Virginia is a state with many rural areas

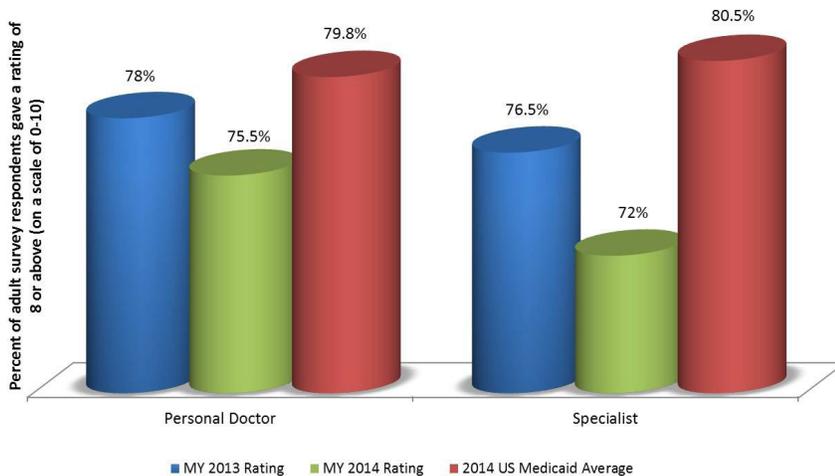
and that the number of specialist available to all state residents is limited.

Adults also reported satisfaction with their ability to both receive care when needed and receive timely care. Eighty-three percent of adults in MCOs responded that they were "usually" or "always" able to get the appointments and services as soon as they were needed, which is above the national Medicaid average.

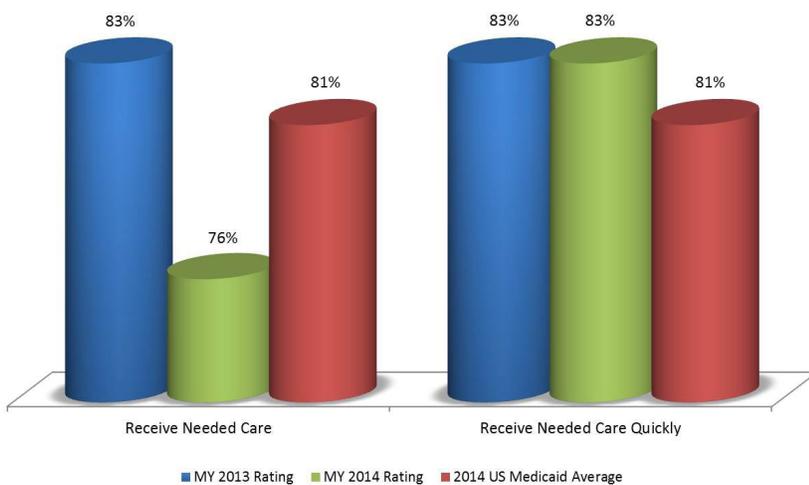
For areas in which the survey results demonstrated need for improvement, BMS has required the MCOs to implement action plans for improvement including actions such as additional outreach to members and training for staff. The improvements focus on areas such as educating providers on culturally sensitive communication, hiring more quality staff, and recruiting and retaining additional specialists in the MCOs' networks. The plans are required to report on the success of these initiatives quarterly.

The next member survey will be mailed to a sample of members in the fall of 2016. BMS will continue to monitor the results of the survey to determine opportunities for improvement for both the MCOs and PAAS program in order to provide the best quality of care possible.

Adults were satisfied with their personal doctors & specialists



Adults in MCOs were satisfied with both the access to and timeliness of needed care in 2014



"I don't like to go to the dentist, but I am glad I can when my tooth hurts."

MHT Medicaid Member

Members Continue to have High Levels of Access under the MHT Program

BMS contracts with an independent vendor to perform an External Quality Review of measures related to quality, access, and timeliness of care for members in MHT. The organization that performs the review, the EQRO, ensures that MCOs are compliant with all applicable federal and state requirements and that they meet all of the MHT program standards outlined in the State of West Virginia's contract with each MCO. The EQRO also reviews medical records and conducts onsite audits to ensure that MCO policies and procedures, such as those related to grievances and appeals systems and notifying enrollees of their rights, are properly administered.

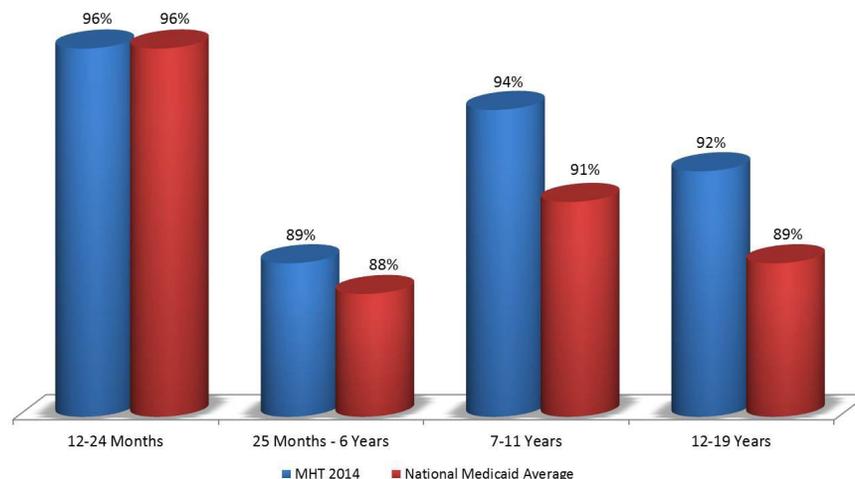
The EQRO uses the Healthcare Effectiveness Data and Information Set (HEDIS) to measure and validate MCO performance on quality, access, and timeliness of care indicators. HEDIS measures, maintained by the National Committee for Quality Assurance (NCQA), are considered the gold standard for measuring performance and are used by over ninety percent of health plans. The EQRO uses the HEDIS results for the MCOs to create recommendations for improving the quality of care delivered to MHT beneficiaries.

Ensuring that beneficiaries have access to preventive services is an essential component of delivering high-quality care. Thus, increasing rates of preventive care has been an important focus for the MCOs. HEDIS results for Calendar Year (CY) 2014, which is the latest year data is available, demonstrated that the vast majority of children and adolescents enrolled in the MHT program visited their PCP at least once during the year. For all age groups between 12 months and 19 years, the MHT average across all three MCOs met or exceeded the national Medicaid averages for the percentage of children and adolescents with a PCP visit in the measurement year.

"I would refer everyone to Mountain Health Trust... I trust them and they are willing to go the extra mile to get things done. Thank you."

MHT Medicaid Member

For every age group for children and adolescents, the MHT average is near or exceeds the national Medicaid average for the number of members with a PCP visit

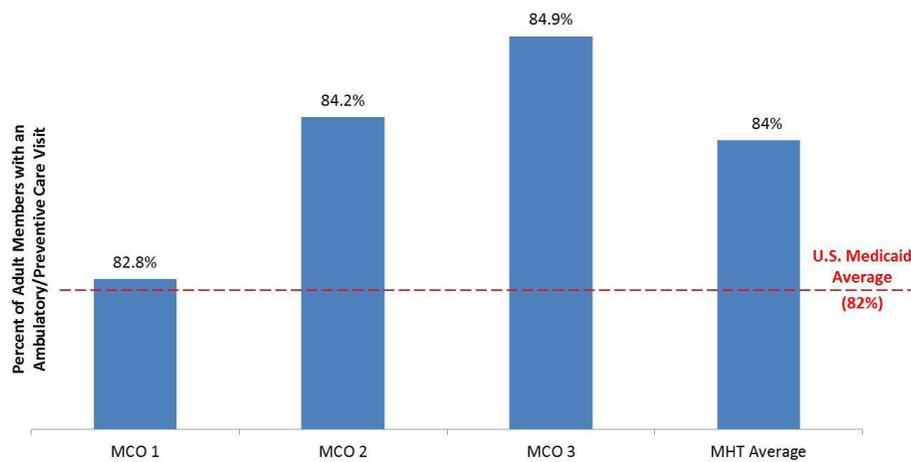


BMS is committed to increasing access to preventive and ambulatory health services for adults in the MHT program. Adult members in the MHT program also have high rates of preventive care, exceeding national Medicaid averages.

In CY 2014, the MHT average (83.9%) exceeded the national Medicaid average, 82%.

WVFH will report HEDIS data in June 2016 after having a full year of operations.

The MCOs exceeded the national Medicaid average for the percentage of adult members with an ambulatory or preventive care visit



“You take really good care of my Dad!”



MCOs Deliver Quality Care

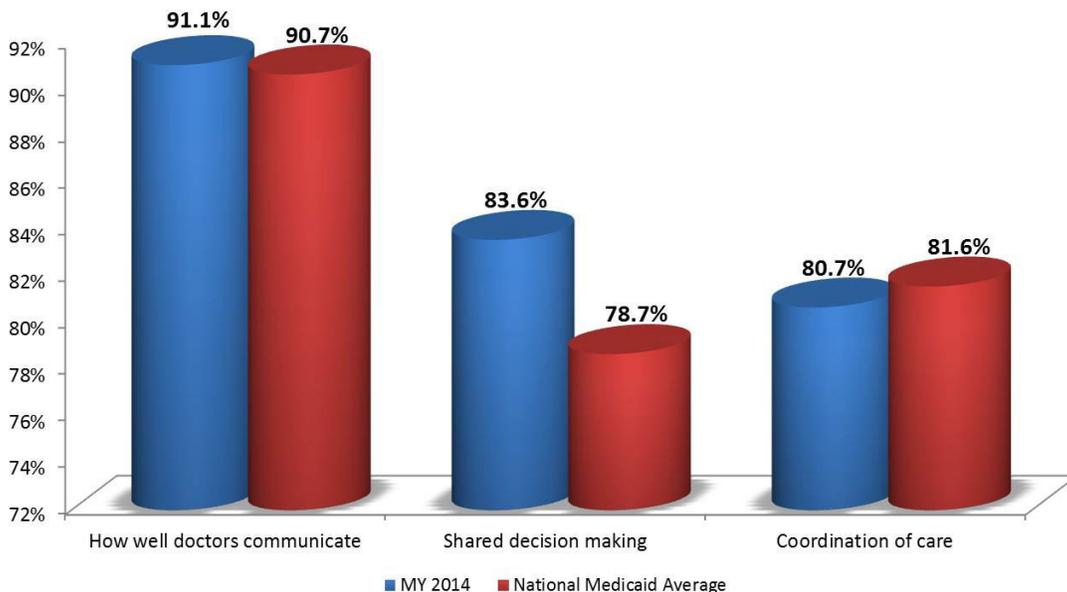
In CY 2014, the MCOs performed well in doctor-patient communication and care coordination. Ratings for how well doctors communicate (91.1%), shared decision making (83.6%), and coordination of care (80.7%) improved since CY 2013. While how well doctors communicate and shared decision making exceeded the national Medicaid averages, coordination of care was slightly lower and may present an opportunity for improvement.

The MCOs performed consistently well in the percent of pregnant women receiving timely prenatal care. Rates for the number of women with timely prenatal care have been consistently high over the past several years. For CY 2014, all three MCOs reported rates of women receiving a timely prenatal care visit that were over 89% and the MHT average for all of the MCOs was 90.7%. Each MCO surpassed the national Medicaid average for women receiving timely prenatal care, 82.4%.

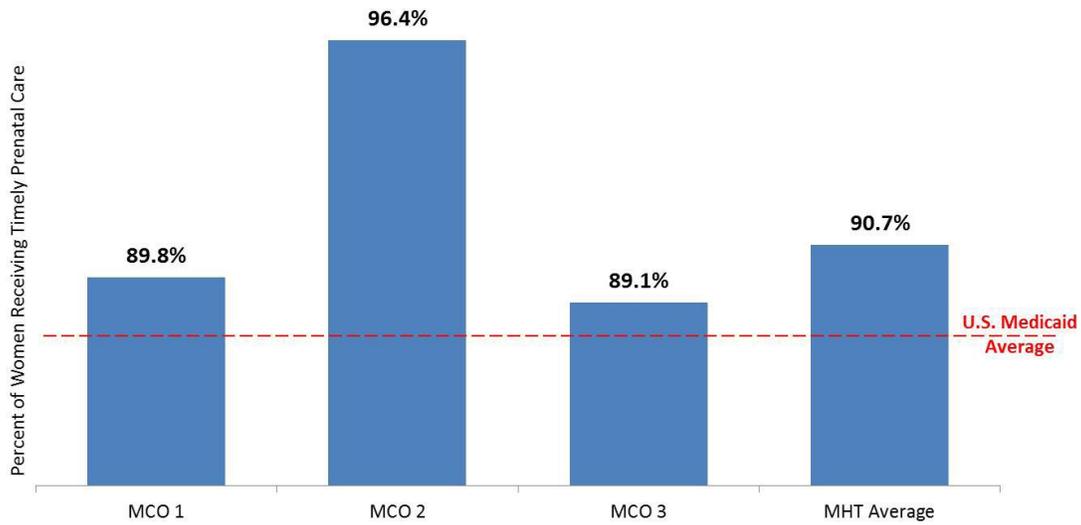
Administration of regular preventive screenings for children, known as Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) in Medicaid, is an important part of any health program. MHT places particular emphasis on increasing the number of children who regularly receive these services. BMS is committed to increasing the number of members receiving well-child visits in order to find, diagnose, and treat health problems before they become lifelong issues or permanent disabilities.

The MCOs encourage children to complete well-child visits and receive EPSDT services. The MHT average (61.9%) is higher than the national Medicaid average (58.7%) for the percentage of members who received six or more visits during the first 15 months life.

The MHT program is improving its rate doctor-patient communication, shared decision making, and coordination of care



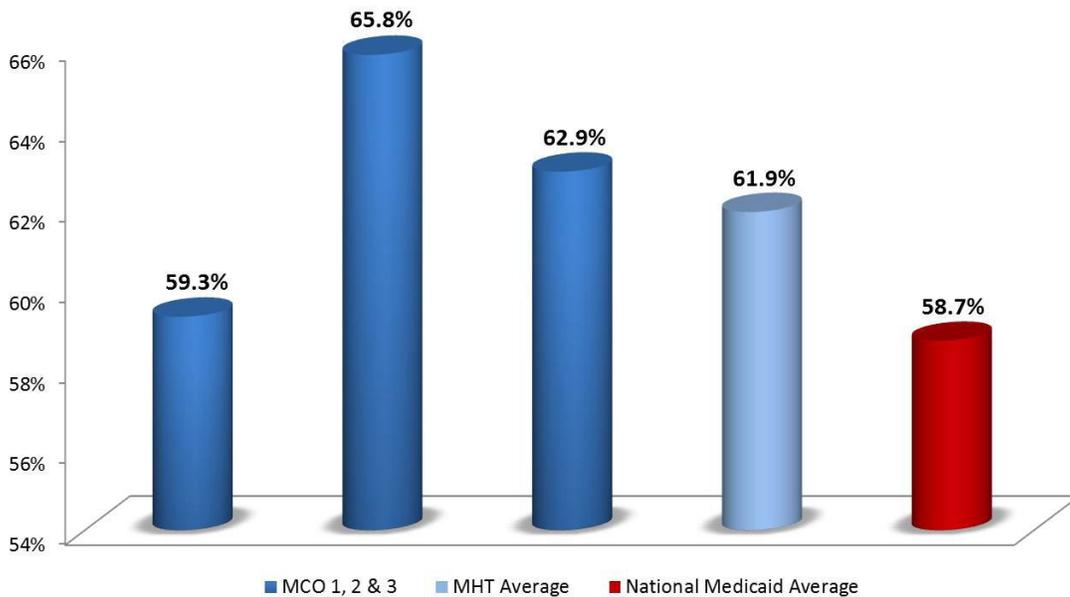
The MHT Program performed better than the national Medicaid average and Medicaid 90th percentile for timeliness of prenatal care



“Love this program!”

Comment on Well Child Drive Questionnaire

Each MCO performed above the national Medicaid average for the number of children who had at least six well-child visits in the first 15 months of life



MCO Member Services Centers are Responsive to Members

In addition to access to medical care, members were also able to seek help through MCOs' member services centers. This was an area of focus for the MCOs in 2014. The plans worked to improve performance through:

- Updating member packet and call script information
- Conducting satisfaction surveys at the end of member calls
- Instituting additional training for customer service staff

In SFY15, BMS began using performance withhold incentives to drive increases in five measures that reflect key program priorities and were identified as areas in need of improvement. These measures are as follows:

- Well child visits for children ages three to six years
- Adolescent well-care visits
- Immunizations for adolescents
- Medication management for people with asthma (75% compliance) – ages 5 to 64
- Prenatal and postpartum care – postpartum care

All of the plans met or exceeded the targeted benchmarks in at least three of the measures. All received a significant portion of their withhold capitation funding.



What is Ahead for the MHT Program

In SFY 2015, the MHT program saw significant growth and improvement. BMS plans to continue these efforts in SFY 2016. The children's dental benefit was transitioned into managed care effective January 1, 2014. BMS has begun laying the foundation to transition the behavioral health benefit as well as the ACA Medicaid Expansion population. BMS is dedicated to enrolling all eligible individuals in the Mountain Health Trust program. BMS will continue working with the enrollment broker and MCOs to conduct outreach and enrollment activities throughout the State, especially in counties where the MCO program is currently being expanded. Individuals and families will receive information about their MCO choices, the enrollment process, and a guide to using the Mountain Health Trust program.

As always, BMS is continuing to explore ways to improve its own monitoring activities. Efforts such as expanding reporting requirements for MCOs to ensure the quality of claims data and requiring each MCO to develop action plans on areas for improvement identified from the CAHPS survey promote continuous improvement in the Mountain Health Trust program. BMS has increased coordination with other State bureaus, particularly the Medicaid Fraud Control Unit, to identify and combat fraud, waste, and abuse in the Medicaid program. BMS is exploring new mechanisms to drive greater improvements in quality of care and accountability that will be incorporated into the SFY 2016 managed care contract.

Through these activities, BMS is committed to improving the quality of care received by all Medicaid members.





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