WEST VIRGINIA MEDICAID MOUNTAIN HEALTH PROMISE

ANNUAL REPORT

State Fiscal Year 2024
(July 2023 - June 2024)

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WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Bureau for Medical Services

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Program Overview

What is Medicaid?

Medicaid is an important safety net in the healthcare system, providing publicly funded health insurance coverage to millions of low-income Americans. The program was signed into law in 1965 and authorized under Title XIX of the Social Security Act (SSA). It began as a cash assistance program for parents and children with low income and people with disabilities. Medicaid has evolved over time to cover more people and offer a broad array of health care services.

Who Does Medicaid Help?

Medicaid provides medical care to eligible U.S. citizens in their communities or in institutional settings, such as nursing homes, who otherwise may not be able to afford care. Federal law requires states to cover certain groups of individuals, such as families with low income, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI). States also have the option to cover other groups of individuals who otherwise may not be eligible under the federal standards. Medicaid provides a comprehensive set of services, including basic medical care and preventative treatment, as well as ancillary services like transportation and long-term care support.

How is Medicaid Funded?

Medicaid is funded by a federal and state government partnership that shares the cost of covering eligible individuals. The Centers for Medicare & Medicaid Services (CMS) establishes a Federal Medical Assistance Percentage (FMAP) rate each year for every state. This FMAP varies across states and provides reimbursement to states based on the average per capita income for each state relative to the national income average.

States, like West Virginia, with lower average incomes[1] receive higher reimbursement rates from the federal government to support Medicaid program costs. This means that the federal government carries a larger share of the financial burden of West Virginia's Medicaid program.

[1] United States Census Bureau American Community Survey (2022).

In federal fiscal year (FFY) 2024, West Virginia's starting FMAP rate was 74.10%. This means the federal government reimbursed West Virginia approximately $0.74 of every eligible dollar spent on Medicaid. Please visit this link to learn more about FMAP.

Agency Overview

Department of Human Services (DoHS)

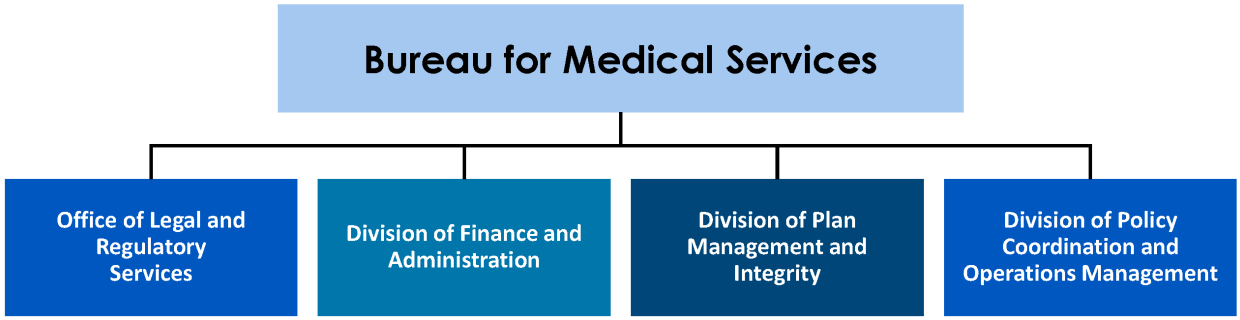
DoHS is the State's organization responsible for supplying a wide range of health care services for the residents of West Virginia. DoHS's mission is to promote and provide health and human services to the people of West Virginia in order to improve their quality of life and health outcomes. DoHS is comprised of the following areas:

- Bureau for Social Services.
- Bureau for Medical Services.
- Bureau for Child Support Enforcement.
- Bureau for Family Assistance.
- Bureau for Behavioral Health.
- Office of Drug Control Policy.
- Boards and Commissions.

Bureau for Medical Services (BMS)

BMS is the designated single state agency responsible for the administration of the State's Medicaid program and for providing access to appropriate health care for Medicaid-eligible West Virginians. BMS establishes and administers overall strategic direction and priorities for the Medicaid program. BMS is organized into various divisions and sections, each of which works together to achieve the effective and efficient administration and support of the overall Medicaid program. The four BMS divisions are identified in *Figure 1*. The Office of Managed Care within the BMS Division of Plan Management and Integrity monitors and oversees the Mountain Health Promise (MHP) program.

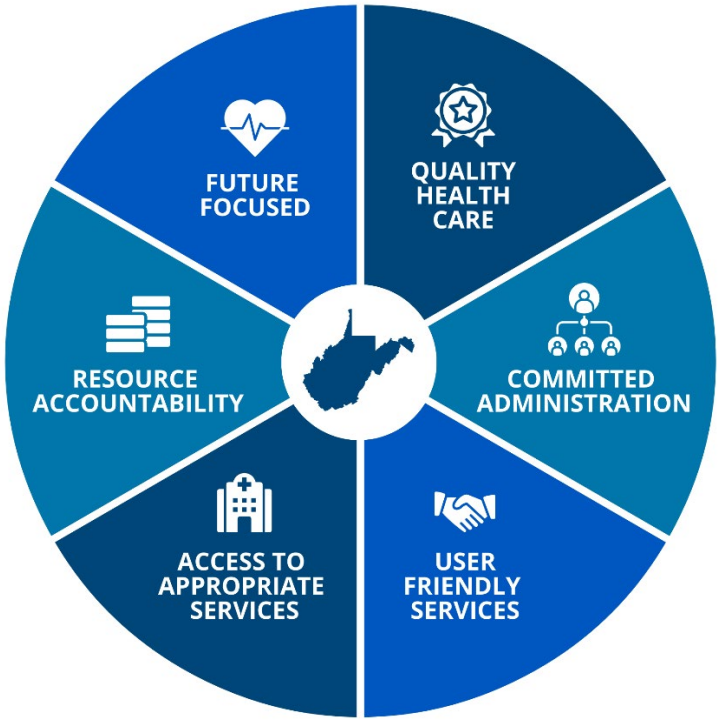
Figure 1: BMS Organizational Structure



BMS Mission

BMS is committed to administering the Medicaid program, while maintaining accountability for the use of resources in a way that ensures access to appropriate, medically-necessary, and quality health care services for all members; providing these services in a user-friendly manner to providers and members alike; and focusing on the future by providing preventive care programs. See *Figure 2* for a visual depiction of the West Virginia BMS Mission.

Figure 2: West Virginia BMS Mission



Program Oversight

The BMS Medical Services Fund Advisory Council (MSFAC) meets quarterly to provide BMS with input on the Medicaid Services Fund, disbursements from the Fund and the provision of health and medical services. The MSFAC includes providers, members, legislators, and agency staff who advise BMS on a range of issues, including quality activities and program administration. These MSFAC meetings provide the State with a high level of oversight for program administration issues and promotes continuous improvement in all aspects of the Medicaid program (e.g., enrollment, health care delivery, external monitoring, etc.).

Mountain Health Promise (MHP)

Program Overview

MHP is a specialized managed care program that BMS implemented in March 2020 under Section 1915(b) waiver authority of the SSA of 1981.[2] This section provides states the flexibility to modify their Medicaid program delivery system, including implementation of managed care. The MHP program provides comprehensive physical and behavioral health services, children's residential care services, and socially-necessary services administration. While certain services, such as pharmacy, long-term care, and non-emergency transportation, are still provided on a fee-for-service basis, the MHP program provides a holistic approach to health care services.

Every two years, states are required to renew their 1915(b) waivers and report program monitoring results on the prior waiver period.

At the end of SFY24 the MHP program serves approximately 27,565 children and youth in the following populations:

- Children and youth in foster care or the adoption assistance program, which includes kinship care and legal guardianship.
- Children ages three to 21 who are concurrently enrolled in the West Virginia Children with Serious Emotional Disorders 1915(c) Waiver (CSEDW), which provides an array of home and community-based services (HCBS) that enable children to remain in their home and community.

Throughout state fiscal year 2024 (SFY24) to present, BMS contracts with one managed care organizations (MCO), Aetna Better Health of West Virginia (ABHWV), to serve members of the MHP program. Visit the ABHWV website to view a list of covered services under the MHP program.

Medicaid members that qualify for MHP are automatically enrolled into the program. Adoptive parents are able to disenroll their children by contacting the DoHS customer service center.

MHP Program Support

Additional support is provided to the MHP population through coordination with DoHS's Bureau for Social Services (BSS), the Bureau for Public Health, the Foster Care Ombudsman (FCO), and the Office of Constituent Services. BSS's mission is to promote the safety, permanency, and well-being of children and vulnerable adults, supporting individuals to succeed, and strengthening families. The Bureau for Public Health is a key partner in providing health care services. The FCO is an independent, impartial, and confidential resource that advocates for the rights of foster children and foster/kinship parents, investigates and resolves complaints, and makes recommendations for systemic reform. Additionally, the Office of

[2] SSA of 1981, Sec. 1915. [42 U.S.C. 1396n].

Constituent Services provides support in the form of prompt and accurate reporting services for questions regarding member benefits.

MHP Enrollment and Demographic Information

At the end of SFY24, ABHWV had 27,565 members enrolled in the MHP program.[3] Approximately half of MHP program members are children and youth in the adoption assistance program. Children and youth in foster care represent 40% of enrollment, followed by 9% of members in kinship care and legal guardianship. Approximately 6% of total enrolled members are served by the CSEDW.

Figure 3: MHP Enrollment by Eligibility Category

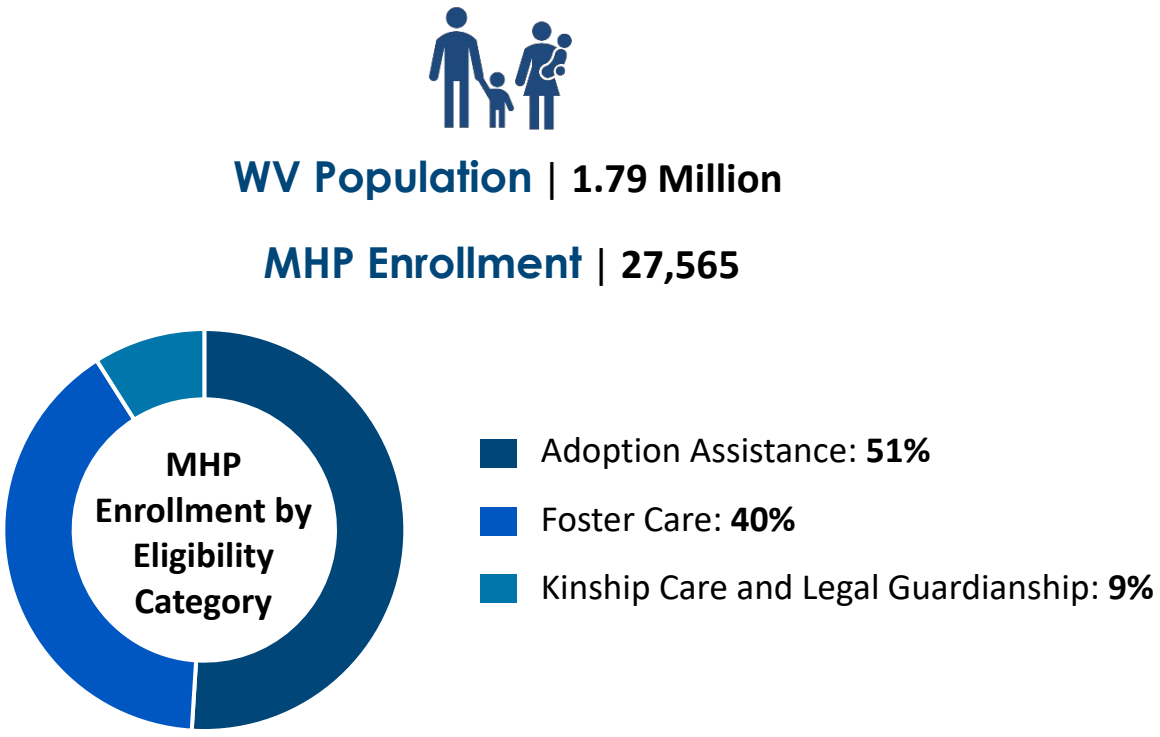
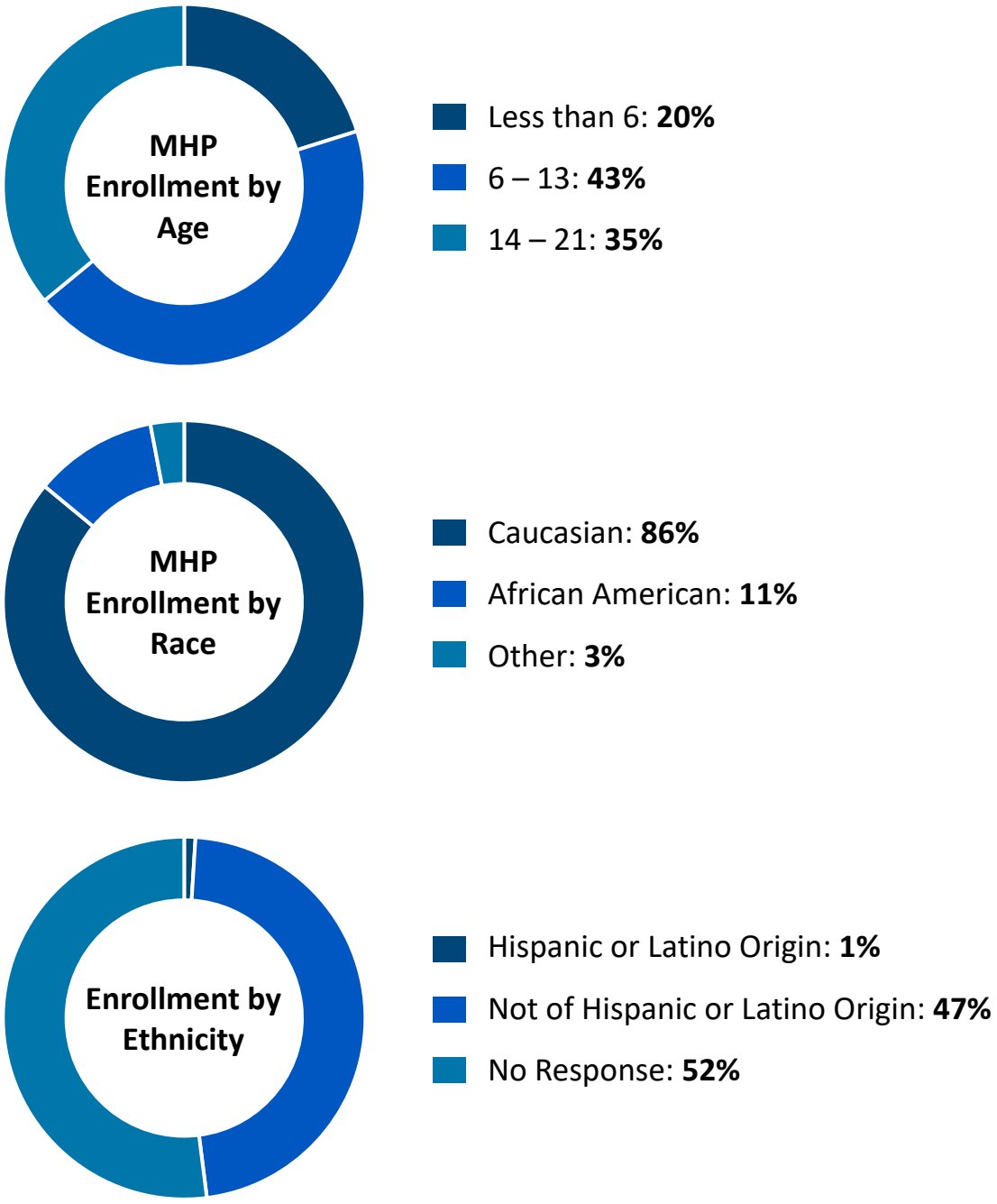


Figure 4 provides MHP program enrollee breakdown by the demographic categories of age, race, and ethnicity. Please note that populations of less than 1% are not represented.

[3] Ibid.

Figure 4: MHP Enrollment by Age, Race, and Ethnicity

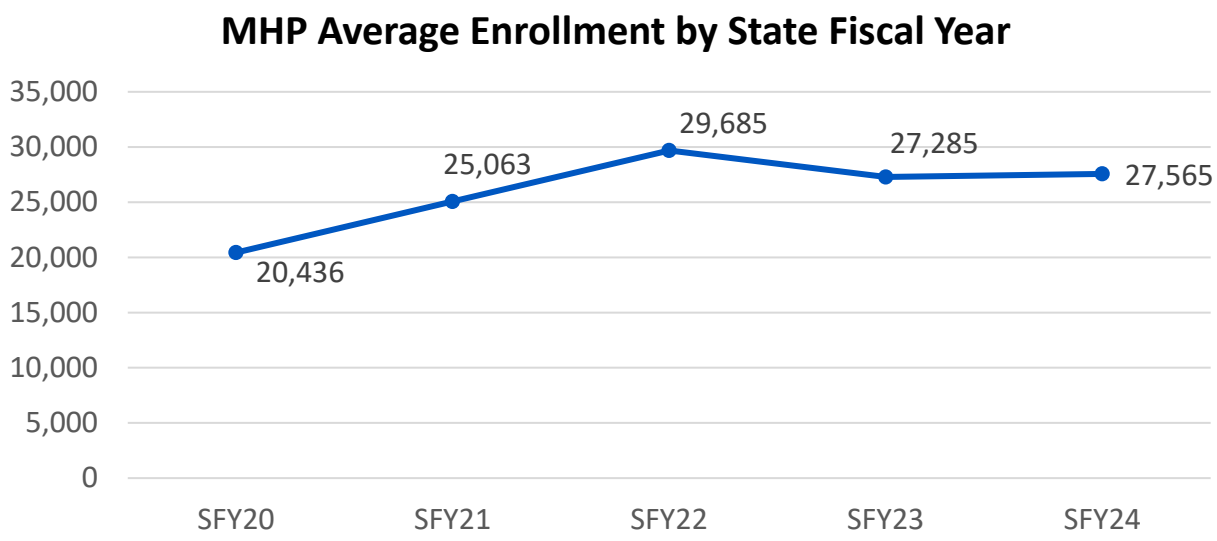


The public health emergency (PHE) resulting from COVID-19 had a significant impact on Medicaid enrollment in recent years. CMS suspended Medicaid disenrollment and ensured eligible enrollees remained covered during the PHE. Continuous enrollment ended with the PHE expiration in May 2023 and West Virginia completed redetermination processes to ensure a seamless return to routine operations, including a transition process to minimize member burden and promote continuity of coverage. *Figure 5*[4] shows the steady increase in the number

[4] Ibid.

of individuals enrolled in the program from SFY20 through SFY22 with declines in average enrollment in SFY23-SFY24.

Figure 5: MHP Average Enrollment by State Fiscal Year



Program Expenditures

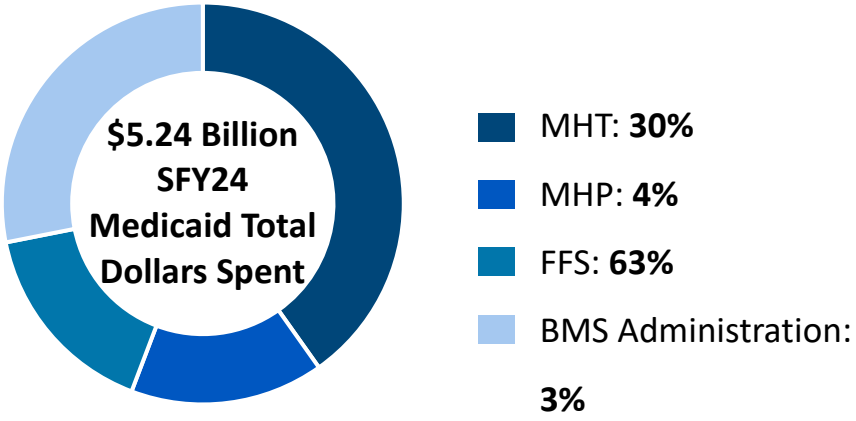
The data presented in this section reflects the total SFY24 expenditures for the Medicaid programs. The figures below present the percentage of total expenditures sourced from the federal and state spend for SFY24. Medicaid members in West Virginia receive care through one of two delivery methods; Medicaid managed care and fee-for-service. The MHP SFY24 expenditures (*Figure 6*) represent approximately 4% of the total federal and state spend. West Virginia's Mountain Health Trust (MHT) program totals approximately 30% of total dollars spent, while 63% is attributed to fee-for-service.

Figure 6: SFY24 Medicaid Spending by Program

Spending	
$189.1 Million Total MHP Expenditures in SFY24*	MHP accounts for **4% of total SFY24 Medicaid Spending**
80% federal dollars	20% state dollars
Total Federal Spend $151.4 million	**Total State Spend** $37.6 million

*Includes $46.3 million total funds for the Children with Serious Emotional Disorder Waiver.

Spending



Federal and state percentages actual spending based on CMS-64 reporting and may be impacted by the FMAP change during the PHE.

Children with Serious Emotional Disorder Waiver (CSEDW)

The CSEDW is an HCBS waiver program authorized in the 1915(c) SSA. The 1915(c) waiver permits states to provide HCBS to support participants 3-21 years of age who reside both in state and out-of-state, to support children and adolescents residing in their homes and communities, in order to decrease the use of psychiatric residential treatment facilities.[5]

Members eligible for the CSEDW are automatically enrolled in MHP. ABHWV provides services under the CSEDW and 1115 Substance Use Disorder (SUD) waiver. ABHWV is responsible for coordinating physical, behavioral health, dental, and socially-necessary services for each enrolled member. Members have a primary care provider that acts as their medical home. The medical home promotes high quality, patient-centered care by providing a continuous source of care that is coordinated and accessible to the member.

[5] DoHS CSEDW Waiver

Measure of Success: MCO Community Support

BMS supports the MCOs' community-based investments within the state, which support health outcomes. In SFY24, ABHWV invested in numerous community initiatives to improve MHP members' health such as:

- Provided over **$4.2M in grants to behavioral health/CSED providers** to expand services offered to MHP members.
- Made a **$500K investment with National Youth Advocate Program** to complete a family-centered treatment program for State behavioral health providers.
- Contributed **$100K to Children's Home Society** to purchase "comfort cases" for MHP-eligible members. The "cases" are age-specific and have necessary supplies for children moving within the child welfare system.

Department of Justice (DOJ) Agreement

The DOJ agreement with DoHS and multiple state agencies involves the services, programs, and activities offered to children with serious mental health conditions. On June 1, 2015, the DOJ notified West Virginia that it did not comply with Title II of the Americans with Disabilities Act. The DOJ agreement addressed the allegations regarding BMS' service system for children with serious mental health conditions. The DOJ population of interest includes children under the age of 21 who:

- Have a serious emotional or behavioral disorder or disturbance that results in a functional impairment, and (1) are placed in a residential mental health treatment facility, or (2) reasonably may be expected to be placed in a residential mental health treatment facility in the near future.
- Meet the eligibility requirements for mental health services provided or paid for by DoHS.

DoHS committed to reforming its child welfare system and ensuring children could receive mental health services in the most integrated setting appropriate to meet their needs.

In recent years, BMS worked to prevent children with serious mental health conditions from being needlessly removed from their family homes to obtain treatment, preventing those children from unnecessarily entering residential mental health treatment facilities, and transitioning children who have been placed in these settings back to their family homes and communities. BMS ensures children covered by this agreement receive sufficient community-based services to prevent unnecessary institutionalization. Successful reform has reduced the number of children unnecessarily placed in residential mental health treatment facilities and the length of stay for children at these facilities.

Child Residential Care Overview

Residential treatment facilities are a type of live-in, out-of-home care placement for children and youth whose specific needs are best addressed in a highly structured environment with trained staff. These placements are time-limited and offer a higher level of structure and supervision than what can be provided in the home setting. The centers often incorporate educational components, mental health services, and life skills training to address the unique needs of each child. The goal is to create a stable and supportive environment that fosters growth and development. A goal of the MHP program is to prioritize in-state placements for residential care services whenever possible. This approach aims to minimize disruptions to the child's support system and facilitate easier access to family visitation.

Average Length of Stay (ALOS) for Members in In-State and Out-of-State Psychiatric Residential Treatment Facilities and Group Homes

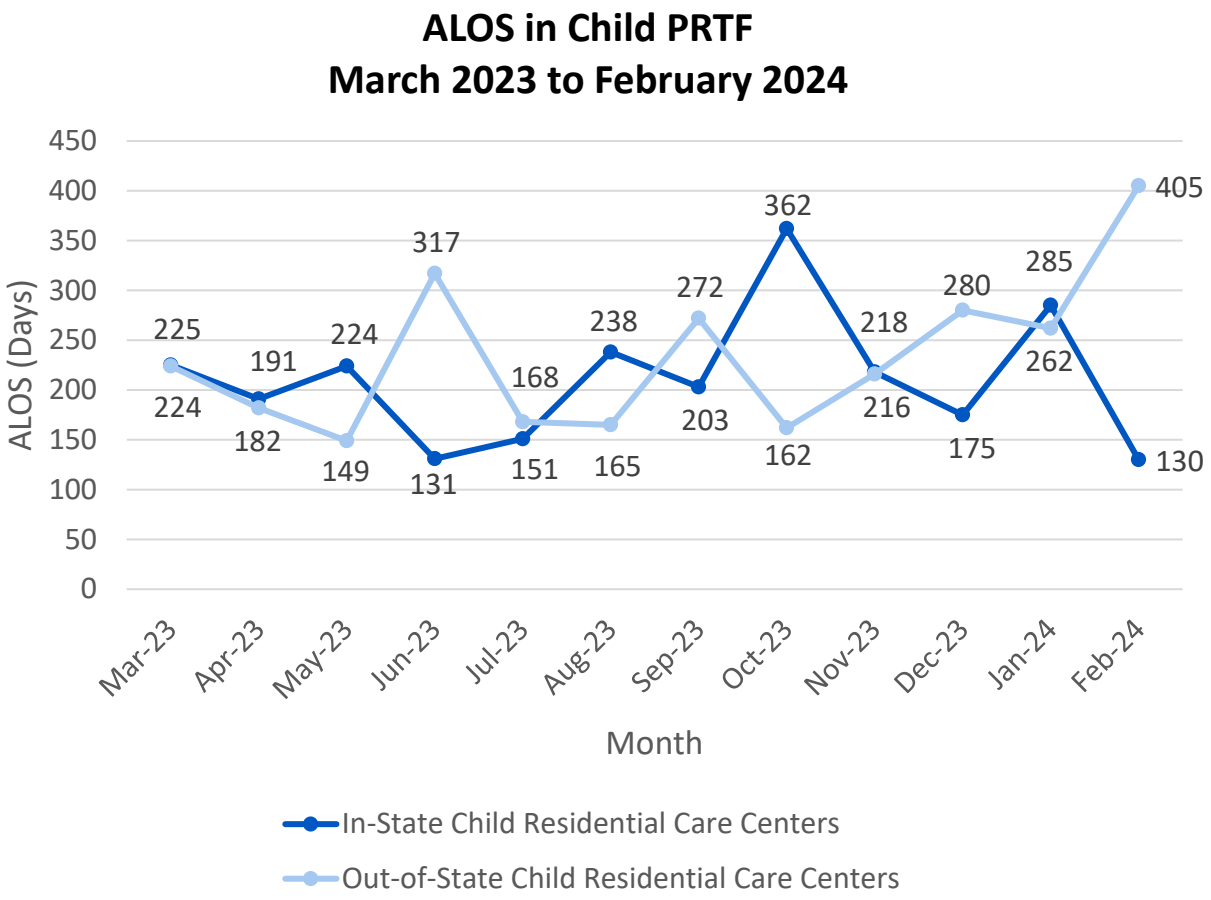
Monthly ALOS is calculated as the total length of stay, in days, for all members discharged during the month, divided by the total number of enrollees discharged for the month. *Table 1* details the ALOS for MHP members in in-state and out-of-state psychiatric residential treatment facilities (PRTF) and group homes by month. The out-of-state data reported by ABHWV was collected from case management and utilization management reports used within its organization. If enrollees appeared on multiple reports, data that was most complete and showed the longest ALOS for those enrollees was used.

Table 1: ALOS in Child Residential Care Centers and Group Homes by Month for March 2023 to February 2024

ALOS in Child Residential Psychiatric Treatment Facilities and Group Homes by Month for March 2023 through February 2024				
Date	**In-State Facilities**		**Out-of-State Facilities**	
	ALOS in Child PRFT	ALOS in Group Homes	ALOS in Child PRFT	ALOS in Group Homes
Mar-23	225	139	224	257
Apr-23	191	116	182	339
May-23	224	163	149	240
Jun-23	131	163	317	237
Jul-23	151	135	168	321
Aug-23	238	123	165	242
Sep-23	203	129	272	382
Oct-23	362	125	162	283
Nov-23	218	108	216	275
Dec-23	175	147	280	237
Jan-24	285	148	262	333
Feb-24	130	110	405	317

The ALOS for MHP members in in-state and out-of-state PRFT and group homes by month from March 2023 through February 2024 is shown below in *Figure 7*, as well as a comparison of monthly ALOS for in-state and out-of-state PRTF. [6]

Figure 7: ALOS in Child PRTF March 2023 to February 2024



The ALOS data from March 2020 to February 2024 suggests that the MHP program is making significant strides in reducing the length of out-of-state placements, while improving in-state placements for child residential services. There has been a slight increase, 0.42%, in the number of youth placements out-of-state; however, it should be noted that all out-of-state placements are currently court ordered.[7] While the MHP program has not yet hit its goal of reducing out-of-state placements, BMS, BSS, and ABHWV are actively working on improving in-state resources and support services to better accommodate the needs of youth and meet the goal in the near future.

[6] BMS Monthly MCO reporting.
[7] ABHWV monthly reports from February 2020 through May 2024.

Early and Periodic Screening, Diagnostic, and Treatment Benefit

MHP Performance Oversight

ABHWV is charged with ensuring MHP member access to critical and comprehensive health care services. Over the past SFY, BMS worked with ABHWV to enhance and streamline required reporting for the early and periodic screening, diagnostic, and treatment (EPSDT) benefit. States are obligated to deliver all Medicaid services specified in Section 1905(a) that are suitable and medically required to address and improve health conditions.

According to federal regulations, EPSDT offers a full range of preventive health care services for children under 21 who are covered by Medicaid. EPSDT services encompass: [8]

- **Early:** Assessing and identifying problems early. For example, a pediatrician conducts a yearly physical to monitor a child's growth and development.
- **Periodic:** Checking children's health at periodic, age-appropriate intervals. For example, a child visits their dentist every six months to monitor their growth.
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified. For example, if a provider notices that a child might have some vision impairment, EPSDT would allow the provider to perform diagnostic testing to determine the root cause.
- **Treatment:** Control, correct, or reduce health problems found. For example, if a child is determined to have hearing loss, EPSDT will pay for the child's hearing aid.

Two key EPSDT metrics that CMS, BMS, and the MCOs monitor are the screening ratio and the participation ratio.

- The screening ratio reflects the extent to which beneficiaries received the recommended number of well-child screenings during the year; however, this information is aggregated and therefore cannot be used to determine whether individual beneficiaries received the recommended number of well-child screenings. The ratio addresses the absolute number of examinations rather than the number of individuals receiving examinations. The screening ratio is calculated by dividing the number of screenings performed by the number of screenings expected.
- The participation ratio is calculated by dividing the number of members who received a screening or medical examination by the number of members who should have received the screening or medical examination.

[8] Medicaid.gov. Early and Periodic Screening, Diagnostic, and Treatment.

- Both ratios are important to determine the overall number of screenings performed by each MCO and to determine the percentage of children receiving the recommended/required screenings.[9]

Table 2 compares the MHP program's screening and participation ratio metrics to the national average. BMS and ABHWV actively monitor program activities and performance metrics to create strategies and initiatives to promote the EPSDT benefit and improve health outcomes.

Table 2: MHP EPSDT Metrics

Metric	ABHWV%[10]	National Average[11]
Screening Ratio	71%	69%
Participation Ratio	58%	54%

As shown in *Table 2*, the MHP program is performing better than the national average for screening and participation ratios. However, ABHWV has identified several barriers to improving EPSDT rates:

- Transportation and access in rural areas.
- Limited appointment availability for well-care visits compared to sick visits.
- Parents are less likely to take a child out of school for a well-child visit.
- Providers who extend their hours often focus on acute care rather than preventive services.
- Engaging adolescents in preventive care becomes increasingly difficult as they age.

Despite the above challenges, the MHP program is actively developing targeted strategies, outreach initiatives, and community partnerships to enhance EPSDT screening and participation rates.

BMS and its contractor conduct EPSDT oversight using the encounter data (MCO claims and payment data) submitted by ABHWV to validate reporting and provide additional data points in EPSDT calculations. In early 2024, BMS implemented new quarterly reporting requirements to enhance ESPDT metrics, especially outreach aimed at increasing mental health screenings for youth.

[9] MCO-reported data.
[10] Data is Myers and Stauffer/BMS calculated by MCO reporting for FFY 2023 (October 1, 2022 through September 30, 2023).
[11] Data is CMS calculated by MCO reporting for FFY 2021 (October 1, 2020 through September 30, 2022).

Quality Assurance

External Quality Review

Annual Technical Report

A core component of the BMS mission is to guarantee services provided for Medicaid members are not only effective, but also readily available and delivered efficiently. The Annual Technical Report (ATR), published by BMS, serves as a valuable tool for understanding the program's performance and identifying areas for improvement.

Want to Know More?

Click here to view the 2023 Annual Technical Report.

To achieve these objectives, BMS relies on its contracted external quality review organization (EQRO) vendor, Qlarant Quality Solutions (Qlarant), to conduct an independent review to assess the compliance of West Virginia's Medicaid program. During the process, Qlarant examines the performance of the program, assessing its strengths and identifying any areas for improvement. The external review focuses on areas such as service quality, service accessibility, and timeliness of care.

When the EQRO completes its evaluation, BMS demonstrates its commitment to transparency and accountability by publishing the ATR. The report is a public document outlining the findings of the review and detailing how well the State has managed the Medicaid program and the contracted MCOs. This report serves as a valuable tool for guiding future program development and ensuring continued high-quality healthcare access for West Virginia's Medicaid beneficiaries.

External Quality Review Conclusions

Qlarant's evaluation found that West Virginia's MHP program continue to make significant progress in improving the quality of, and access to, healthcare services for its Medicaid members. ABHWV was largely compliant with federal and state managed care requirements.

Qlarant also noted that ABHWV demonstrated its commitment to quality and quickly responded to recommendations or requests for corrective actions. Performance continues to trend in a positive direction and provides evidence of improved quality, accessibility, and timeliness. Qlarant observed that ABHWV was methodical in its approach in reaching Performance Improvement Project (PIP) and Quality Improvement goals. ABHWV created member, provider, and MCO interventions. The interventions included member incentives, provider incentives, children's wellness clubs, educational workshops, and no-cost transportations. These interventions addressed root causes or barriers to improvements and led to improvements in processes and health outcomes. ABHWV will continue to create goals and objectives to improve the health services and health outcomes for MHP members.

MCO Quality Performance Profile

Accreditation

Health plans (or MCOs) earn National Committee for Quality Assurance (NCQA) accreditation through an independent review of the health plan's systems and processes, which evaluates multiple dimensions of care, service, and efficiency. An NCQA accreditation survey involves on-site and off-site evaluations conducted by a survey team of physicians and managed care experts. NCQA health plan accreditation standards are used to perform gap analysis and determine areas of improvement.

Want to Know More?

For more information on the NCQA accreditation process, detailed information on plan ratings and a full report on each Health Plan (MCO) visit here.

Health plan ratings differ from accreditation. A plan's overall rating is the weighted average of the plan's Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measurement ratings. Plans also earn bonus points for current accreditation. The overall rating is based on a 5-point scale (1=lowest performance/5=highest performance). MCOs achieve certain distinctions through NCQA, including but not limited to the electronic clinical data and health equity accreditation. This distinction recognizes organizations that have accepted a rate for a non-publicly reported measure that leverages electronic clinical data and was originally introduced for the HEDIS electronic clinical data systems reporting standard. See *Table 3* for ABHWV accreditation, rating, and distinction.

Table 3: MCO Accreditation

MCO	NCQA Accredited	Overall Rating[12]	Additional Program[13]
ABHWV	Yes	4	Electronic Clinical Data & Health Equity Accreditation

Health Outcomes

HEDIS Measures

HEDIS®[14] is a comprehensive set of standardized performance measures designed by NCQA to assess the effectiveness of various health plans and provide consumers with the information they need to compare health plan performance. Qlarant conducted EQR activities in West

[12] 5-point scale (1=lowest performance/5=highest performance).
[13] Electronic Clinical Data distinction recognizes organizations that have an accepted rate for a non-publicly reported measure that leverages electronic clinical data and was originally introduced for the HEDIS Electronic Clinical Data Systems Reporting Standard.
[14] HEDIS® – Health Care Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Virginia throughout SFY24 and evaluated MCO compliance for measurement years (MY) 2021 and 2022. This inclusion allows for a comparative analysis of each MCO's performance over time, highlighting trends and areas for improvement. It is important to note that some HEDIS measure specifications are updated or retired, and new measures are introduced over time to better align with health data standards and support new models of care delivery. This may influence the interpretation of certain year-over-year trends.

Table 4 highlights MHP state-mandated and ABHWV selected PIP measures available for MY 2022, covering March 2022 through February 2023. The PIPs are effective tools in identifying barriers and implementing targeted interventions for the MHP program. The table compares the ABHWV MHP results to the NCQA quality compass national benchmark. Due to the MHP program implementation date of February 1, 2020, the number of performance measures available are limited.

Table 4: MHP State and ABHWV PIP Measures[15]

Performance Measures	MY 2022 (ATR 2023)	Comparison to National Benchmark[16]
(ADV) Annual Dental Visits (2-3 Years)^	44.1%	♦♦
(IMA) Immunizations for Adolescents – Combination 2^	32.1%	♦
(PDENT) Percentage of Eligibles Who Received Preventive Dental Services^	55.5%	NC
(WCV) Child and Adolescent Well-Care Visits (12-17 Years)^	57.8%	♦♦♦
(WCV) Child and Adolescent Well-Care Visits (18-21 Years)^	24.5%	♦
Out-of-State Placements in Foster Care^^ *(lower rate is better)*	6.2%	NC

Findings from the 2023 ATR demonstrate that ABHWV and BMS are focused on improving performance measure outcomes and the MHP program is performing better than the national average in several areas. For example, the national average for well-child visits in the first 30

[15] Table legend adapted from WV 2023 ATR:
^State-mandated PIP measure.
^^MCO-selected PIP measure.
NC Not Calculated indicates an average rate and/or comparison to benchmarks could not be calculated due to unreported data and/or no benchmark available.
♦♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 90th percentile.
♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 75th percentile, but does not meet the 90th percentile.
♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th percentile.
♦ MCO rate is below the NCQA Quality Compass National Average.
[16] Ibid.

months of life (W30; defined as 15-30 months) is 64.9% and West Virginia is at 78.2%. In addition, the national average for child and adolescent well-care visits (WCV; defined as 3-11 years) is 54.8% and while the MHP program is at 65.7%.

The MHP program has seen improvements in several program measures in the last SFY; however, there are areas where ABHWV can improve. The incremental improvement in program measure outcomes is likely influenced by the COVID-19 PHE. The pandemic posed significant challenges and disruptions that likely impacted the ability to fully realize the benefits of the MHP program interventions across all targeted areas. BMS continues to monitor MCO reporting to ensure quality services and improvements are continuously addressed and adapted based on emerging needs and data insights. *Table 5* includes additional performance measures of interest for the MHP program.

Table 5: Additional MHP Performance Measures[17]

Performance Measures	MY 2022 (ATR 2023)**	Comparison to National Benchmark[18]
(FUA) Follow-Up After Emergency Department Visit for Substance Use – 30-Day Follow-Up (13-17)	63.2%	♦♦♦♦
(FUA) Follow-Up After Emergency Department Visit for Substance Use – 30-Day Follow-Up (Total)	56.0%	♦♦♦♦
(FUM) Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-Up (6-17 Years)	76.7%	♦♦
(FUM) Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-Up (Total)	73.1%	♦♦♦
(IMA) Immunizations for Adolescents – HPV	32.8%	♦
(W30) Well-Child Visits in the First 30 Months of Life (0-15 Months)	60.8%	♦♦
(W30) Well-Child Visits in the First 30 Months of Life (15-30 Months)	78.2%	♦♦♦♦
(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile (Total)	83.0%	♦♦
(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for	74.2%	♦♦

[17] **ABHWV's HEDIS measure results combine performance in both the MHT and MHP programs per NCQA reporting requirements.

♦♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 90th percentile.

♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 75th percentile, but does not meet the 90th percentile.

♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th percentile.

♦ MCO rate is below the NCQA Quality Compass National Average.

[18] Ibid.

Performance Measures	MY 2022 (ATR 2023)**	Comparison to National Benchmark[18]
Children/Adolescents – Counseling for Nutrition (Total)		
(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity (Total)	73.0%	♦♦
(WCV) Child and Adolescent Well-Care Visits (3-11 Years)	65.7%	♦♦♦
(WCV) Child and Adolescent Well-Care Visits (Total)	55.9%	♦♦♦

Figure 8: Measure of Success-Quality Improvement

Measure of Success: Quality Improvement

In SFY24, ABHWV shared the following quality improvement activities for the MHP program:

- Established **new and enhanced existing supplemental data feeds** with large healthcare systems allowing digital transfer of patient level clinical data needed to supplement HEDIS reporting and ensure robust accounting of care received in order to close care gaps.
- **Enhanced Healthy Rewards incentive program and Value-Added Benefit offerings** for members who achieve timely and recommended preventive care and care related to chronic disease management.

Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Children with Chronic Conditions (CCC) Population Measures

The CAHPS®[19] survey is a tool used for measuring patient experience with health care. The survey assesses health care quality by asking patients to report their health care experiences. The child CAHPS for the CCC population survey specifically focuses on the experiences of children with chronic conditions and their caregivers.

[19] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

The 2023 CAHPS member satisfaction scores demonstrated slight improvement in the ratings for health plan, healthcare, and specialist. However, ABHWV did not reach its goal for coordination of care, rating of the child's personal doctor or specialist, and rating of the overall health care received. The MHP program was unable to compare all of the CAHPS for the CCC population performance measures to the national benchmarks, either because the denominator for some of the survey result calculations were less than 100 or the MCO did not report data. ABHWV and BMS are actively working to improve CAHPS scores to ensure patients receive safe, high quality, and coordinated care. To view CAHPS measures from the EQRO report, access the report here.

Quality Assurance and Other Medicaid Reports

In addition to the ATR, BMS also produces reports for legislative oversight committees and the public. BMS encourages West Virginians interested in knowing more about the Medicaid managed care program and its administration to visit the resources below for more information.

The DoHS website hosts many archived reports for public review. These reports provide historical insight into different components of the managed care program. Visit the DoHS site to view monthly enrollment figures, quality reports, legislative reports, and past annual reports.

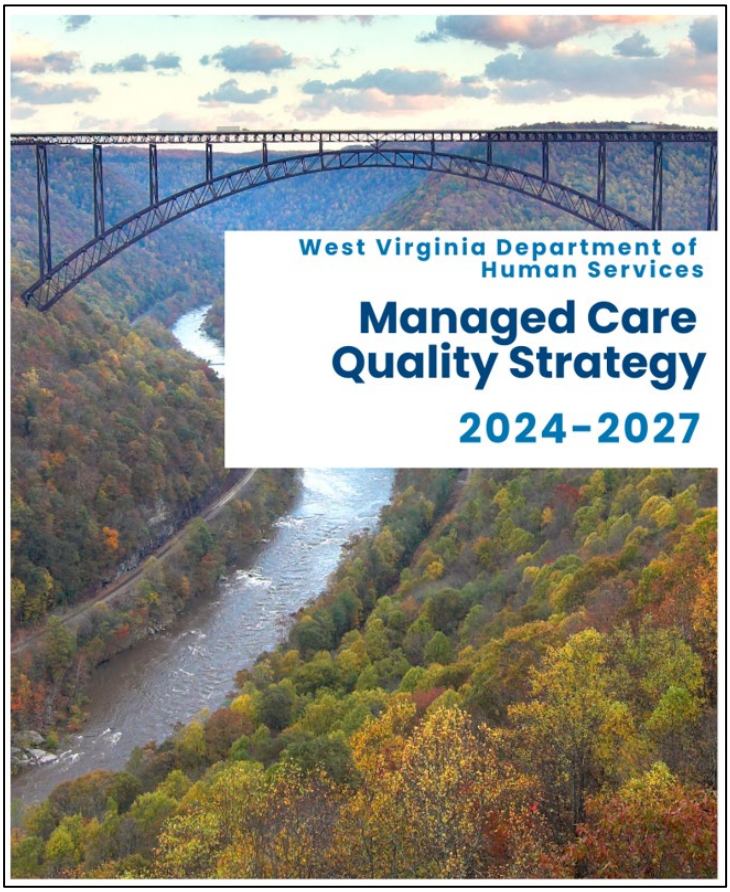
Foster Care Ombudsman

The FCO is a unit within the Office of Inspector General that advocates for the rights of foster children and foster/kinship parents, investigates and resolves complaints, and makes recommendations for child welfare reform. During the 2019 and 2020 legislative sessions, House Bills 2010 and 4094, relating to foster care, enabled an independent FCO. The Ombudsman is required to have experience as a former foster parent or in the area of child welfare. The FCO published an initial report for the MHP program in March 2021, focusing primarily on unit development and initial impressions. Sequential reports, provided on a quarterly basis, aggregate to annual reports in conformance with applicable legislation. To view the first report of the FCO and quarterly reports, click here.

Quality Strategy

Managed Care Quality Strategy

The BMS Office of Quality Management (OQM) is responsible for monitoring and overseeing continuous improvement of the State's two Medicaid managed care programs, MHT and MHP. The OQM leads collaboration with internal and external stakeholders to develop quality initiatives and seek input to ensure delivery of evidence-based, high-quality health care services. OQM partners with numerous stakeholders, including advocates, legislators, providers, and MCOs. BMS also works with representatives from other state agencies, as needed, to raise issues of concern to their constituencies and share information about the managed care programs for their staff and members.



The mission of BMS centers on a commitment to provide quality health care services for all West Virginia Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) members. Pursuant to this goal, OQM developed the 2024-2027 West Virginia Managed Care Quality Strategy. The purpose of the quality strategy is to provide a framework to guide BMS in operationalizing a dynamic approach to assessing, monitoring, and improving the quality of health care provided by the State's MCOs.

The Managed Care Quality Strategy focuses extensively on the following:

- Ensuring alignment of Managed Care Quality Strategy goals, objectives, and measures with BMS initiatives driving health care quality, including the quality withhold program for MHT and value-based payment initiatives.
- Developing methods for MCOs to influence outcomes-based measures and benchmark to national performance measures.
- Establishing a foundation to continually evolve health disparities and equity initiatives in future iterations.

BMS crafted five goals (illustrated in *Figure 11*) to address West Virginia's health challenges to improve quality and health outcomes across the care continuum. In partnership with the State's MCOs, sister agencies (such as the Bureau for Behavioral Health and BSS), and other key

stakeholders, goals were selected to reflect the needs of West Virginia's Medicaid (MHP and MHT) and WVCHIP populations.

Figure 9: Medicaid (MHT and MHP) Managed Care Quality Strategy Goals

Performance measurement is key to monitoring and improving quality. Within each of the five goals identified in *Figure 11*, BMS linked individual performance measures. To the extent possible, BMS relies on national performance measures that support comparisons and benchmark performance against other national, state, and local entities. BMS requires the MCOs to report relevant measures included in NCQA HEDIS®, NCQA CAHPS®, the CMS Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the CMS Core Set of Health Care Quality Measures for Medicaid-Eligible Adults.

As an example, BMS selected performance measures to increase the usage of timely maternal and child health services to achieve Goal 1. Selected performance measures include, but are not limited to, improving timeliness of prenatal care, postpartum care, and monitoring low infant birth weights. Additionally, BMS carefully selected performance measures to align with other quality improvement programs, including the 2024 quality withhold program.

While the desired outcome at the end of SFY27 is to meet or exceed measure thresholds set by NCQA, BMS has outlined interim targets for incremental progress over the three-year course of the Managed Care Quality Strategy. This approach allows the OQM to actively coordinate and drive quality improvement and monitor progress systematically. Details related to performance targets are found in *Appendix B* of the 2024-2027 Managed Care Quality Strategy.[20]

[20] BMS 2024-2027 Managed Care Quality Strategy.

Access to high-quality health care is an essential element in fostering healthy and prosperous communities and families.[21] BMS is committed to a strong quality and performance improvement approach that ensures managed care programs will continue to deliver quality, accessible care to members while simultaneously driving improvement in key areas. The quality measures selected for this strategy, paired with comprehensive managed care program reporting, monitoring, and evaluation, will support BMS in achieving its goals.

MHP Program Goals

BMS has established clear goals and objectives for the MHP and MHT programs, which are intended to drive specific, measurable, and attainable improvements in care delivery and outcomes. The State faces challenges in a number of largely preventable areas such as high incidence of SUD,[22] high prevalence of chronic conditions,[23] and poor ranking in lifestyle habits and health outlook. The goals and objectives outlined in the Managed Care Quality Strategy focus on addressing these avoidable health conditions that affect some of the most vulnerable populations in the state, including members enrolled in the MHP program. The BMS goals identified in *Figure 11* support the challenges faced by the MHP population. In SFY24, BMS amended the MHP program goals to align with the State's 2024-2027 Medicaid Managed Care Quality Strategy.

Monitoring Program Outcomes

West Virginia Code §9-5-27 requires the MHP program to publish several managed care reports to the Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA). The reports aim to present key program metrics including claim numbers, ALOS in a child psychiatric residential treatment facility, and average turnaround time of a MHP claim appeal. The reports also include detailed evaluations of the managed care program and evaluate ABHWV's progress towards the MHP goals. BMS filed the initial report in July 2021 and published the final report in July 2023. MHP programmatic reports can be found on the BMS reports website. While legislatively required reporting concluded in SFY24, BMS continues to carefully monitor achievement of key quality metrics to ensure progress toward program goals.

[21] West Virginia Executive. Hurdles to Health, The State of Health Care in West Virginia. Miller, Olivia. February 22, 2023. Accessed on July 22, 2024.
[22] West Virginia Department of Health. DHHR Releases 2016 West Virginia Overdose Fatality Analysis. (n.d.). January 23, 2018. Accessed on January 31, 2024.
[23] America's Health Rankings. 2021 Annual Report, West Virginia. Accessed on February 15, 2024.

Program Integrity

The BMS Office of Program Integrity (OPI) is dedicated to the identification and prevention of fraud, waste, and abuse in the West Virginia Medicaid program. As the gatekeeper of program integrity, OPI ensures that Medicaid services are billed and administered in accordance with applicable standards, and that public funding for healthcare services is used as effectively as possible by working closely with participating MCOs as well as state and federal law enforcement entities.

BMS has continued to facilitate direct coordination between MCOs and law enforcement agencies, resulting in improved communication. The collaborative efforts between BMS, law enforcement, and MCOs have significantly enhanced the support for investigations, contributing positively to the overall integrity of the Medicaid program. This approach has enabled OPI to support the timely recovery of identified overpayments as well as the long-term integrity of the Medicaid program, ensuring that the system remains robust and effective in preventing fraud, waste, and abuse.

BMS has observed a continued commitment from participating health plans to enhance Medicaid program integrity. MCOs work in collaboration with BMS to maintain and improve program integrity by initiating new audits, referring credible allegations of fraud, and providing education to providers.

Program Integrity Metrics

Throughout SFY24, BMS observed the program integrity activities of all MCOs within the MHT and MHP programs (*Table 6*). Metrics include the number of new audits initiated, the number of fraud referrals and total overpayment recoveries.[24]

Table 6: Program Integrity Metrics

West Virginia SFY24	
	Total
Number of New Audits Initiated	297
Fraud Referrals	23
Overpayment Recoveries	$ 1,345,549.26

[24] SFY23 overpayment recovery data is not available. SFY22 data is reported based on data provided in the SFY22 annual report and, due to change in reporting platforms, cannot be verified for SFY24.

West Virginia SFY23	
	Total
Number of New Audits Initiated	218
Fraud Referrals	35
Overpayment Recoveries	$ 1,503,543.36

West Virginia SFY22[25]	
	Total
Number of New Audits Initiated	174
Fraud Referrals	18
Overpayment Recoveries	$ 1,977,424.50

In SFY24, BMS noted a marked increase in the number of prepayment reviews implemented by the MCOs (*Table 7*). By implementing prepayment reviews of providers that have a history of non-compliant billing behaviors plans reduce the risk of improper payments and are better able to identify and leverage opportunities for provider education. By coordinating these efforts across all stakeholders, pre-payment reviews minimize the risk of disrupting ongoing law enforcement investigations while maximizing the ability of participating managed care plans to oversee the quality and appropriateness of Medicaid payments. This increase will continue to have a significant impact on provider billing compliance and enhance the overall integrity of the Medicaid program.

Table 7: SFY24 Prepayment Reviews

Prepayment Reviews	Total
Total Prepayment Reviews	46
Total Billed Amount	$ 601,366.96
Amount Cost Avoided	**$ 168,115.57**

[25] SFY22 data is reported based on the SFY22 annual report and, due to change in reporting platforms, cannot be verified independently.

Additional Resources

Program Overview: How is Medicaid Funded?

- Financial Management of Medicaid Services
- Federal Medical Assistance Program
- Your Guide to Medicaid

Quality Assurance

- 2023 Annual Technical Report
- NCQA Accreditation Process
- NCQA's Health Plan Report Card for West Virginia
- West Virginia DoHS Overview of all Medicaid Reports
- Foster Care Ombudsman (FCO) Reporting Resources

Quality Assurance: CMS Adult and Child Core Set

- Adult's Health Care Quality Measures
- Children's Health Care Quality Measures

Additional Medicaid Resources

- DoHS Bureau for Medical Services
- West Virginia Department of Human Services
- Centers for Medicare & Medicaid Services
- Medicaid.gov
- DoHS Local Field Offices
- DoHS's Office of Inspector General - Foster Care Ombudsman

Contact Information

Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
Phone: (304) 558-1700
https://wv.accessgov.com/bms/Forms/Page/contactbms/contact-bms/

Aetna Better Health of West Virginia, Inc.
500 Virginia Street East, Suite 400
Charleston, WV 25301
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Appendix

Acronyms List

Acronym	Definition
ABHWV	Aetna Better Health of West Virginia
ALOS	Average Length of Stay
ATR	Annual Technical Report
BMS	Bureau for Medical Services
BSS	Bureau for Social Services
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Center for Disease Control and Prevention
CMS	The Centers for Medicare & Medicaid Services
CSED/CSEDW	Children with Serious Emotional Disorder/ Children with Serious Emotional Disorder Waiver
CY	Calendar Year
DoHS	Department of Human Services
DOJ	Department of Justice
EQR/EQRO	External Quality Review/ External Quality Review Organization
FCO	Foster Care Ombudsman
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
LOCHHRA	Legislative Oversight Commission on Health and Human Resources Accountability
MCO	Managed Care Organization
MHP	Mountain Health Promise Program
MHT	Mountain Health Trust Program
MSFAC	Medical Services Fund Advisory Council
MY	Measurement Year
NCQA	National Committee for Quality Assurance
OPI	Office of Program Integrity
OQM	Office of Quality Management
PHE	Public Health Emergency

Acronym	Definition
PIP	Performance Improvement Plan
PRTF	Psychiatric Residential Treatment Facility
SFY	State Fiscal Year
SSA	Social Security Act
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
WVCHIP	West Virginia Children's Health Insurance Program