



West Virginia Medicaid Mountain Health Trust Annual Report

**State Fiscal Year 2017
(July 2016 – June 2017)**

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MOUNTAIN HEALTH TRUST PROGRAM OVERVIEW

“You have helped us through a terribly sad time. I appreciate your patience and efforts to get things done quickly for us. I thank you for listening and showing compassion.”

– MHT member

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, children with special health care needs, and low-income childless adults. 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.

Managed Care Organization	Serving West Virginia Members Since
Aetna Better Health of West Virginia	1996
The Health Plan of West Virginia, Inc.	1996
UniCare of West Virginia	2003
West Virginia Family Health	2014

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. 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. The MHT program has implemented a range of initiatives to coordinate and integrate care beyond the traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality

care. 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,
- Containing the escalating costs of Medicaid,
 - Reducing inappropriate use of services,
 - Increasing competition,
- Improving quality,
- Improving population health, and
- Developing a person centered system of care.

BMS actively monitors program outcomes to ensure 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 are discussed in greater depth below.

AFFORDABLE CARE ACT EXPANSION

Under the Affordable Care Act (ACA), West Virginia elected to expand Medicaid coverage to adults under the age of 65 with incomes up to 138 percent of the federal poverty level (FPL) beginning January 2014. In turn, Medicaid enrollment grew by more than 215,000 individuals, resulting in a 56 percent reduction in the State's uninsured rate from 2013 to 2016.⁶ West Virginia ranked fourth-highest in the nation for its percentage drop among the uninsured (17.6 percent in 2013 to 7.7 percent in 2015).⁷ With approximately 573,000 people covered by West Virginia's Medicaid program in June 2016, only six percent of the State's residents remain uninsured.⁸

⁶ This statistic is from the [healthinsurance.org](https://www.healthinsurance.org/west-virginia-medicaid/) website. This statistic can be found at <https://www.healthinsurance.org/west-virginia-medicaid/>.

⁷ *Ibid.*

⁸ *Ibid.*

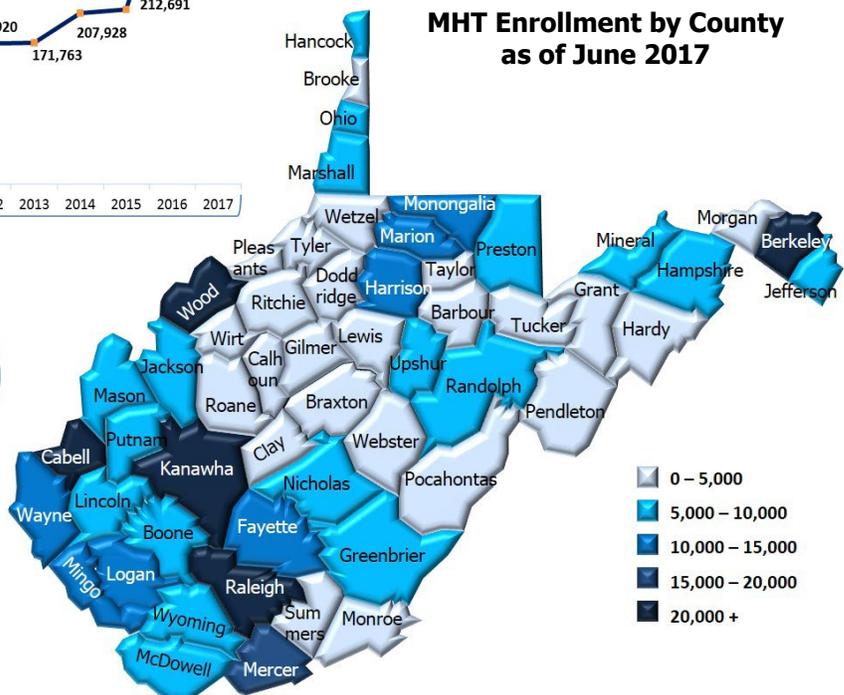
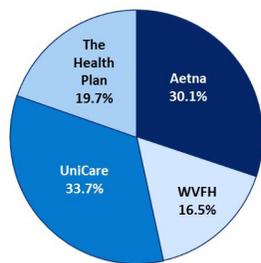
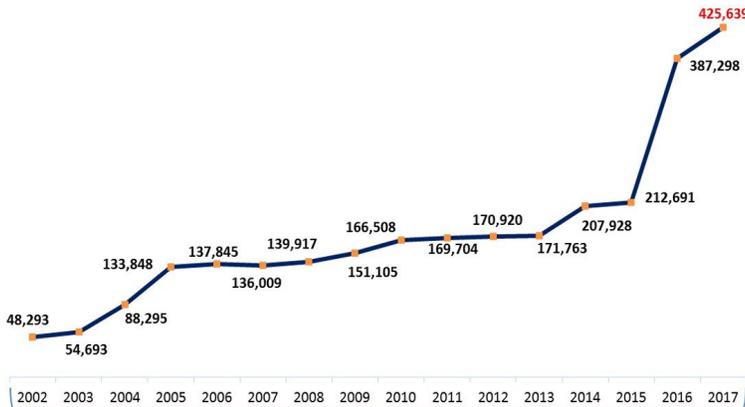
ENROLLMENT IN MCOS IS GROWING

As of December 2015, most Medicaid beneficiaries in each of West Virginia's 55 counties were required to enroll in a contracted MCO. From the end of State Fiscal Year (SFY) 2016 to June 2017, MCO enrollment increased from 387,298 to 425,639 Medicaid members. MCO enrollment has increased more than eightfold since 2002.

The state currently contracts with four health plans to provide services to beneficiaries in its MCO programs; two are for-profit (Aetna Better Health of West Virginia and UniCare of West Virginia), and one is not-for-profit (The Health Plan of West Virginia, Inc.). The fourth, West Virginia Family Health (WV FH) is a provider-sponsored network. WV FH was approved to participate in the MHT

program in 2014 and began serving members on September 1, 2014. The Health Plan of West Virginia, Inc. (The Health Plan) and Aetna Better Health of West Virginia (Aetna) have been under contract since the inception of the MHT program in 1996, and UniCare of West Virginia (UniCare), began enrolling members in November 2003. The MCOs have continued to expand their service areas and enroll new members in the program. The four MCOs are now providing services to MHT beneficiaries in all 55 counties of West Virginia. In effect, the Physician Assured Access System (PAAS), West Virginia's primary care case management program, was phased out in 2015, while all recipients were transitioned into managed care.

In 2017, more than 425,639 members were enrolled in MCOs; almost 65% of members were enrolled with Aetna or UniCare as of June 2017



PROGRAM SERVICES

As of June 2017, West Virginia Medicaid covered 512,992 individuals - approximately 28% of the West Virginia population. There were 87,353 members who were enrolled in fee for service (FFS), i.e. traditional/regular Medicaid. FFS currently covers foster care children and waiver recipients. Approximately 425,639 members were receiving services through MHT, the State's Managed Care Program. MHT includes most children, pregnant women, adults eligible under the ACA expansion, parents, caretaker relatives, and the Supplemental Security Income (SSI) population.

Member Characteristics

Almost half of MCO members are children (43% are 19 years old or younger). This age cohort dropped from prior years with the inclusion of the ACA population, which included low-income childless adults in managed care. Because the MCOs serve a large number of children and adolescents, the program emphasizes screening and preventive care to keep members healthy. MCOs ensure that all services, both clinical and non-clinical, are accessible to members.

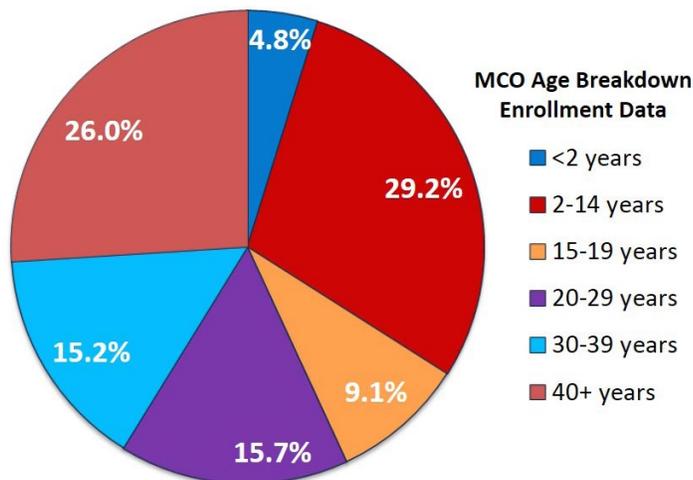
Services Covered by the MCO Program

BMS is required to provide certain services to members to qualify for federal matching funds ("mandatory services"). BMS has also chosen to provide additional services ("optional services") to provide broader care to members.

The following services include both mandatory and optional Medicaid services that are covered by MCOs under the MHT program:

- Ambulatory surgical center services
- Behavioral health outpatient services
- Behavioral health rehabilitation (Children <21)
- Cardiac rehabilitation
- Chiropractic services
- Clinic services
- Dental services (children)
- Diabetes education and management
- Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Children <21)
- Emergency dental services (adults)
- Family planning services and supplies
- Handicapped/ Children with special health care needs services
- Home health care services
- Hospice care services
- Hospital services, inpatient
- Hospital services, inpatient - behavioral health and substance abuse stays
- Hospital services, outpatient
- Inpatient psychiatric services (Children <21)
- Inpatient rehabilitation
- Laboratory and x-ray services, non-hospital
- Nurse practitioner services
- Occupational therapy
- Personal care services
- Physical therapy
- Physician services
- Podiatry services

43% of MCO members were 19 years old or younger



- Private duty nursing
- Prosthetic devices and durable medical equipment
- Psychiatric residential treatment facility
- Psychological services
- Pulmonary rehabilitation
- Right from the Start services
- Rural health clinic services (including federally qualified health centers)
- Speech therapy
- Tobacco cessation programs
- Transportation, emergency
- Vision services

Currently, the only services not covered by the MCOs are abortions, early intervention services for children three years of age and younger, transplants, nursing facility services (nursing homes), Medicaid Waiver services (aged & disabled, intellectual and developmental disabilities, and traumatic brain injury), non-emergency medical transportation, personal care services, prescription drugs, and school-based services. These services are available through traditional Medicaid (also known as FFS).

As of July 2017, pharmacy benefits for members enrolled in MCOs were transitioned back into FFS to reduce pharmacy costs and improve efficiencies. BMS continues to ensure continuity and coordination of care by providing MCOs with each member's pharmacy utilization data. Conversely, the SSI population was carved into managed care beginning January 2017. With the expansion of the managed care program, eligible SSI beneficiaries began to experience increased assistance with coordinating their healthcare, increased access to medical professionals who provide care to individuals with disabilities and complex medical conditions, and increased satisfaction with their care and overall improved health status. The SSI group that moved into managed care does not include those members that receive Medicare, Medicaid waiver services, residents in long term nursing facilities or children in foster care services. As of July 2015, BMS added behavioral health and substance use disorder services to the MHT program.



DISEASE & CARE MANAGEMENT

All Medicaid MCOs have embraced care management, developing programs that help members with chronic diseases and other complicated conditions to lead healthier lives. Each of the conditions identified by the MCOs is prevalent in West Virginia (cardiac-related conditions, chronic obstructive pulmonary disorder, diabetes, smoking, obesity, and substance use disorders) or is of particular risk to Medicaid beneficiaries (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. Through their case management programs, MCOs work to identify members with chronic or high-risk conditions and educate them about appropriate use of medications and methods of self-management. Where applicable, the programs also incorporate lifestyle influences.

Aetna has an integrated care 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 utilizes predictive modeling, and provides a method to ensure health care is improved for specific, eligible members, while medical costs are managed to the appropriate level. The program focuses on the continuum of care, ad-

resses the health care needs of a limited number of members, and stresses medically appropriate care and member involvement in the health care process. Members complete face-to-face visits with the case manager to further assist in the plan of care. Aetna 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. The care management team partners closely with the Aetna Healthcare Effectiveness Data and Information Set (HEDIS) team to identify members with potential gaps in care to facilitate services.

The Health Plan's Care and Complex Case Navigation Program is the care delivery model used to coordinate and manage services across the care continuum. Nurse navigation is a collaborative approach to provide and coordinate healthcare services to a defined population. The Health Plan Catastrophic Navigation Program identifies members who have had a major health event or diagnosis that requires the extensive use of health care resources. Nurse Navigators provide assistance to those members with extended acute hospital stays, discharge follow-up issues, problems identified on the Health Risk Assessment, medical, nursing or behavioral health needs. By incorporating analytical reporting, enrollees can be stratified based on complexity of medical conditions, gaps-in-care,

West Virginia Health Statistics in 2015⁴

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)	14.0% (95% CI: 13.0-14.9)	8.4% (95% CI: 8.2-8.5)	1
Chronic Obstructive Pulmonary Disorder (COPD)	13.3% (95% CI: 12.4-14.3)	6.3% (95% CI: 6.1-6.4)	1
Diabetes	14.5% (95% CI: 13.5-15.4)	10.5% (95% CI: 10.3-10.7)	2
Smoking	25.7% (95% CI: 24.3-27.1)	16.7% (95% CI: 16.5-17.0)	2
Obesity	35.6% (95% CI: 34.1-37.1)	28.9% (95% CI: 28.6-29.1)	4
Drug Overdose Deaths (2016) ⁵	52%	19.8%	1

⁴ This statistic is from the West Virginia Health Statistics Center, Behavioral Risk Factor Surveillance System, 2014.

⁵ These statistics are from the Centers for Disease Control and Preventions, National Center for Health Statistics, 2017.

*The percentages and numbers of persons estimated to be at risk are subject to sampling error.

avoidable ER use, and readmissions. Those with the highest risk scores are provided immediate access to clinical services programs, and others are assigned based on these metrics. The Coordinated Care Summary Report generated by an analytical software program provides the nurse with an overview of all care rendered within the past 12 months, highlighting the services related to evidence-based care protocols and multiple comorbidities that may be driving inefficiencies, poor quality and outcomes. The Health Plan's Chronic Disease Navigation Programs are multidisciplinary and continuum-based systems, developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes, chronic cardiac conditions, and chronic obstructive-pulmonary disease (COPD).

UniCare's Disease Management (DM) programs offer a holistic, member-centric care management model that provides interventions tailored to unique healthcare needs of 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 accredited by the National Committee for Quality Assurance (NCQA) since 2006, including but not limited to bipolar disorder, hypertension, asthma, and diabetes. All identified members receive condition specific educational materials. 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.

WVFH's hallmark disease management program, Gateway to Lifestyle ManagementSM (GTLM), focuses on improving the health outcomes and well-being of members with chronic conditions such as asthma, 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. Members are provided with tools such as pillboxes to assist with medication adherence, digital scales to monitor weight fluctuations for members with heart failure, and the opportunity to earn value added rewards in the form of gift cards for good health practices. Ongoing care coordination with care plan development is offered as warranted, and members are provided with education and resources to assist them with self-management of their health conditions. Members have access to a wide selection of searchable educational material and videos through the WVFH Member Portal. GTLM continually evaluates clinical, humanistic and economic outcomes with the goal of improving overall health. WVFH members can be identified for case management services through multiple means including enrollment data, health risk assessments,

and risk stratification and includes targeted outreach and interventions based on need. WVFH utilizes an integrated care model for member management that includes multiple disciplines

MCO's Role in Treating its Members with Effective Solutions

"It was very helpful to have someone to talk to about my medical situation, who was concerned and supportive. I would recommend them to anyone! I am so very thankful for all they have done for me. Without it, I would not have been able to take care of my health problems."

— Unicare member

including case management, utilization management, medical management, and pharmacy.

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

Cardiac-Related Chronic Conditions

All MCOs offer disease management programs that work with members affected by 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, incentives, 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, West Virginia had the highest rate of cardiovascular disease in the nation. BMS continuously works to identify best practices across the plans to promote improvements among members, since cardiovascular disease disproportionately affects low-income populations.

Aetna provides Chronic Condition Management for members with diagnoses of coronary artery disease and/or heart failure. Chronic Condition Management aims to improve the quality of care and disease outcomes for members living with coronary artery disease and heart failure. Through a multidisciplinary approach to cardiac management, as well as self-management support, members are encouraged to assume greater responsibility for their health. This is accomplished through collaboration, engagement, identification of strengths and leveraging those strengths to enhance resiliency and result in members' improved condition management and



self-efficacy. The objectives of Aetna's Chronic Condition Management interventions are to: increase members and/or caregivers ability to manage their heart disease/failure, increase the number of members using their medications correctly, in both frequency and dosing, and decrease the incidence of ER and in-patient visits related to heart disease and failure. When improved, heart failure management could either prevent such visits, or visits could be provided in a more appropriate setting such as a physician's office, increase the use of preventive care including influenza and pneumococcal vaccination, improve wellness and better overall management of heart disease/failure, resulting in healthier lifestyle choices including diet, exercise and eliminating the use of tobacco. Members' with heart failure are provided home scales and a daily weight log. Members with intensive needs are offered a face-to-face visit in addition to telephonic case management services.

The Health Plan reaches out to members with heart failure and acute coronary artery disease to educate them about the disease process, recognition of symptoms, medication compliance, and lifestyle modification. Nurses make phone calls at periodic intervals determined by the severity of the member's illness. Primary attention is given to appropriate pharmacological treatment, enhancement of self-management skills, and systematic surveillance of those with symptomatic heart failure to prevent hospitalization. Enrolled members also receive home scales, smoking cessation interventions, referrals for nutritional education, referrals for home oxygen/ respiratory care services, cardiac rehabilitation, and immunizations as needed.

UniCare offers an NCQA accredited cardiac disease management program. Members who have an eligible cardiac condition qualify for a free bathroom scale to monitor weight at home and prevent hospital admissions. Smoking cessation counseling is available to all members via the WV Quit Line, and unlimited cessation counseling sessions are available at provider offices. Additionally,



UniCare brought the American Heart Association's CPR Tour to West Virginia. More than 640 individuals were trained in life-saving hands only CPR. UniCare gifted 400 hands only CPR kits to Jackson County High Schools to be used to fulfill the high school graduation requirement.

WVFH invites members with heart disease into the GTLM Program, in which information on heart health is provided, and members are encouraged to contact a case manager if they need assistance managing their cardiac condition. In addition to mailed educational materials 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.

Chronic Obstructive Pulmonary Disease (COPD)

All four MCOs offer disease management programs for members with 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, **Aetna** provides ongoing, comprehensive care that increases the member's awareness of his or her condition and the value of treatment and self-management.

The Health Plan educates members about the disease process, recognition of symptoms, and medication compliance. 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. Enrolled members also receive the following (as needed): home scales, smoking cessation interventions, referrals for nutritional education, referrals for home oxygen/respiratory therapy, pulmonary rehabilitation, and immunizations.

UniCare's NCQA accredited disease management program utilizes Motivational Interviewing techniques to identify and fill knowledge gaps related to condition self-management and engage members in the behavior change process. Educational mailings and referrals are provided as appropriate to reinforce teaching and em-

power members to reach their goals. Smoking cessation counseling services are made available to all members via the West Virginia Quit Line and provider offices.

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. Case Managers provide ongoing assessment, coaching, goal setting, and care plan development. A Wellness Coach dietician is available to assist members with their nutritional needs and meal planning help as needed. Additional educational materials and videos are available to members on the Member Portal to assist in managing COPD and their nutritional needs.

Diabetes

All four MCOs offer care/case management to diabetic members. Goals of these programs include improving glycemic control, optimizing functional capacity, and reducing risk factors. In addition, the MCOs use 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, **Aetna** 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 (CDE) about managing their health. Test results are also sent to the member's PCP for review for any needed treatment change. An Aetna pharmacist then reviews the member's medications and works with the member and PCP to develop an appropriate treatment plan. Aetna has a diabetes collaborative program as well, where face-to-face diabetes education classes are completed. When classes are complete and A1c is drawn, members are eligible for a \$25 gift card. Aetna Better Health's Diabetes Collaborative Program has expanded to

now include seven different educational entities and covers 27 counties in West Virginia.

The Health Plan has three nurses (all CDE) on staff who conduct a telephonic program, face-to-face individual diabetes education, and group sessions. In addition, The Health Plan partners with Med Express urgent care centers to provide alternative sources of care for members with diabetes.

UniCare automatically enrolls diabetic members in an NCQA accredited diabetic disease management program. UniCare offers eligible diabetic members an incentive for taking an active part in managing their diabetes. Eligible members who complete recommended diabetic laboratory testing (HbA1c, LDL, and Urine Microalbumin) by the end of the year are eligible to receive a \$25 gift card. An additional \$50 incentive is offered to eligible diabetic members who complete a diabetic retinal eye examination and nephropathy testing in the same timeframe. Outreach staff notify members that have gaps in care and encourage members to schedule and attend appointments. Members may also access free Weight Watchers and gym memberships to promote healthy eating habits and exercise. Specifically in McDowell County, outreach staff work with members to address healthy shopping, cooking and eating. Supper in a Sack, a pilot program, was recently implemented in conjunction with West Virginia University Extension Services.

WVFH invites members with diabetes into GTLM and provides an informative brochure, containing tips for diabetes management and encouraging members to contact a case manager if they need assistance managing their diabetes. Members are eligible to receive incentives for taking an active role in managing their diabetes. WVFH members receive a personalized Diabetes Care Plan in the mail, which provides information on testing results, such as HbA1c, and reminders for follow-up testing/screening. Members with diabetes are eligible for incentives upon receipt of certain screenings. Through access to a licensed dietitian, Wellness Coach, a CDE, and frequent, brief text messaging with the option of medication and appointment reminders if desired, members are better equipped to manage their diabetes.



Prenatal Care

With 9.4% of West Virginia babies being born with a low birth weight in 2015 as compared to 8.0% nationally,⁶ and Medicaid funding more than half of all births in the state,⁷ prenatal care is of 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. In HEDIS measurement year (MY) 2016, all four health plans exceeded the national Medicaid average of 61% for the Prenatal and Postpartum Care measure.

Aetna strives to improve birth outcomes through member education, facilitating care coordination, addressing substance use disorders 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 the 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

⁶ This number is from the America’s Health Rankings Report for 2015 published by the United Health Foundation. This statistic can be found at <http://www.americashealthrankings.org/WV>.

⁷ This statistic is from the Kaiser Family Foundation’s State Health Facts website. This statistic can be found at <http://www.statehealthfacts.org/>.

Fighting Substance Abuse

A member enlisted with the NAS Program states the program has been helpful in helping her fight substance abuse and receive the necessary support through specialized care, *“Most helpful thing about this program is I am able to stay clean, hold a job and lead a normal life.”*

— Aetna member

pre-term labor. Mothers-to-be identified with substance use disorders are referred to their Neonatal Abstinence Syndrome (NAS) 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. Outreach to mothers enrolled in the NAS program also includes regular reminders to keep scheduled prenatal care appointments. Mothers enrolled in the 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 neonatal intensive care unit (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. Mothers-to-be identified with substance use disorders are followed closely throughout delivery. Infants born with NAS are followed in the NAS program for the first six months of life or longer if necessary. 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 less than 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. 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 mothers who may need a little extra support,
- Educational materials and information on community resources, and
- 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, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), home visitor programs, breastfeeding support and counseling. UniCare also has an interactive voice response (IVR) call program, *“My Advocate,”* which increases outreach to pregnant and postpartum women of all risk levels. Women who attend six prenatal care visits and a postpartum care visit are rewarded with the choice of a convertible car seat or a portable crib and gift cards. Since beginning High Risk Obstetrics, UniCare has reviewed more than 300 Risk Assessment Forms and has enrolled 32 women in High Risk Obstetrics case management. Additionally, UniCare has funded the nationally acclaimed Baby and Me Tobacco Free program, which aims to improve birth outcomes.

The program is available in four counties in West Virginia and is conducted by Right from the Start home visitors.

WVFH's MOM Matters® perinatal program aims to improve maternal outcomes with a focus on both timely and ongoing prenatal care, postpartum care, maternal smoking and substance use as well as reducing psychosocial barriers to care. All WVFH pregnant members receive a prenatal packet in the mail, which includes comprehensive pregnancy information from the March of Dimes, as well as information on smoking cessation, depression and domestic violence. The MOM Matters® program is a two pronged approach, using nonclinical Outreach Navigators and licensed clinical staff. The Outreach Navigators contact new and/or at-risk members and assist with scheduling appointments, obtaining needed interpreter services, making referrals and linkages to services (including transportation as needed to ensure compliance with appointments), and coordinating all necessary services. The Outreach Navigators work 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 Outreach Navigator refers expectant members to an experienced maternity case manager at any point as needed or requested. The clinical case manager provides ongoing coaching for those members who are high risk, and develops and implements an individualized plan of care to support members throughout the pregnancy. Case managers have access to a robust Community Repository to assist with member referrals to resources such as WIC, food pantries, housing, tangible items for the baby, and utilities. Members are encouraged to register for messaging through the national Text4baby program. Through this program, pregnant members receive text messaging related to their trimester of pregnancy and continue receiving messages through the first year of the newborn's life. Members are eligible to earn incentives for receiving care throughout the pregnancy and in the postpartum period. Preventive dental care is also available to our members during pregnancy and up to six weeks postpartum.



Behavioral Health and Substance Use Disorders

According to the Henry J. Kaiser Family Foundation, West Virginia currently faces the highest opioid overdose death rate (36 per 100,000) in the US.⁸ West Virginia's rate is about 3.5 times higher than the overall national opioid overdose death rate (10.4 per 100,000). Concurrently, West Virginia faces the highest all drug overdose death rate of 41.5 per 100,000 people in the U.S.⁹

To combat this severe opioid crisis, BMS implemented a new morphine equivalency edit in the fall of 2016 in partnership with the four MCOs. Chronic users of opioids, who have received greater than 50 average morphine milligram equivalents (MME) per day during a 90 day window, now trigger a prior-authorization case review. The MCOs contact the providers during the prior-authorization process to assist with the program. All four MCOs are cognizant of the opioid crisis and committed to addressing the impact it has on the State's Medicaid members.

Behavioral Health Services Can Help MHT Members

An MCO representative spoke with a member who disclosed that he had recently called the suicide hotline. The representative connected him with behavioral health services and resources to help with food and bills. On the next call, the MHT member expressed his gratitude to the MCO representative stating "You must be my guardian angel."

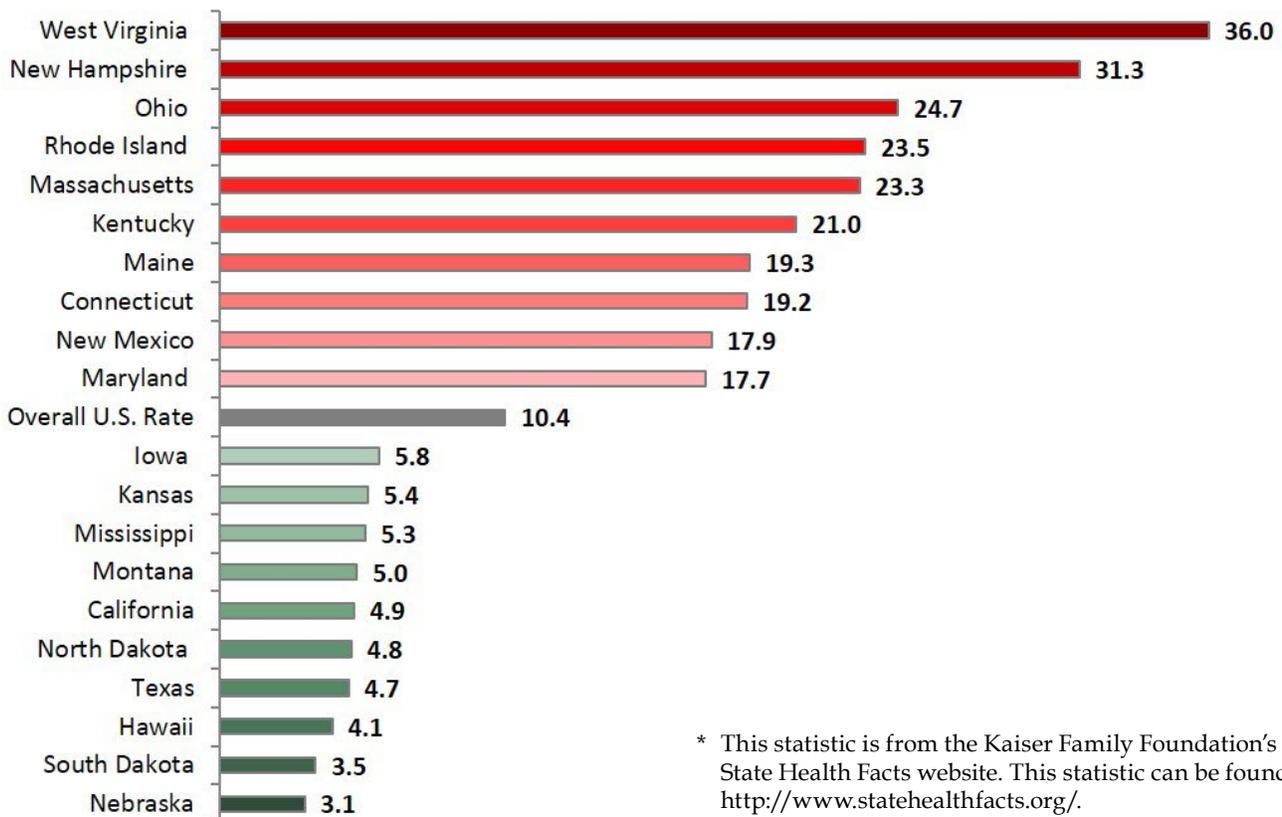
— WVFH

More recent efforts by BMS in collaboration with the Bureau for Behavioral Health and Health Facilities (BBHFF) include a Medicaid Section 1115 waiver proposal to develop a comprehensive and cohesive continuum of care for individuals with substance use disorder (SUD) issues. The waiver

⁸ This statistic is from the Kaiser Family Foundation's State Health Facts website. This statistic can be found at <http://www.statehealthfacts.org/>.

⁹ *Ibid.*

**Opioid Overdose Death Rates per 100,000 (Age-Adjusted):
Top 10 and Bottom 10 States (2015)***



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

will permit the state to increase the availability of SUD prevention and treatment services, with the goal of reducing the number of West Virginia residents that are substance users. This, in turn, will reduce overdose deaths; decrease emergency department visits, inpatient admissions, and readmissions; improve overall health outcomes; and promote economic stability across the state. BMS plans to implement the waiver in July of 2018. The four MCOs will be responsible for contracting with providers to deliver SUD services, conducting provider recruitment and credentialing, and working with the state to ensure network adequacy. The health plans will play an instrumental role in integrating physical and behavioral health for beneficiaries with chronic conditions.



To promote efforts around the SUD waiver, **Aetna** has placed an onsite clinician at a local behavioral health facility to increase collaboration and to expedite discharge planning. Aetna currently contracts with multiple providers across the state to deliver services at a multitude of levels from inpatient acute care through routine outpatient follow-up. Incentive programs have been implemented to encourage follow-up with behavioral health providers. A dedicated multidisciplinary behavioral health team has been established within the plan, focusing on quality, utilization, and the recruitment of new network providers, including those who provide telehealth services. To help providers, Aetna systematically initiates per diem rates for intensive and residential ser-

VICES that will carry forward with the initiation of the SUD waiver.

Shortly after implementation of the behavioral health benefit, Aetna invited behavioral health practitioners and providers to join a multidisciplinary behavioral health workgroup. This Workgroup includes representation from individual behavioral health practitioners, community comprehensive behavioral health centers, inpatient behavioral health facilities, as well as the health plan's Chief Executive Officer, Chief Medical Officer, and representatives from health plan departments including quality management, health services, care management, and operations. This behavioral health workgroup serves a key role in

analysis of data as well as providing feedback directly from the behavioral health practitioners regarding actions for improvement. This group has played an integral role in providing important stakeholder advice about the new behavioral health program.

In preparation for the SUD waiver program, **The Health Plan** has taken steps to educate staff on the new initiatives including coverage of methadone, recovery houses, and residential

treatment. The MCO's Network department has begun contracting efforts with facilities not presently under contract. The Health Plan has increased staffing to adequately navigate the needs of the members by hiring a Certified Addiction Counselor and SUD Care Navigators. They provide alternatives to inpatient hospital treatment, when appropriate, and direct members to the most patient beneficial, cost effective health care option. SUD Care Navigators will educate and monitor a member's participation in therapy requirements necessary for successful participation in the program. The patients are identified by participation in a Medication-Assisted Treatment (MAT) program, health risk assessments, discharge surveys, and daily reports of new prescriptions of Buprenorphine, Buprenorphine/Naloxone or

Naltrexone. The Health Plan's SUD Program is individualized to the member and coordinates resources across the care continuum to minimize costs while improving the quality of care. SUD Care Navigation is a proactive approach that focuses on addiction recovery and member involvement through self-maintenance. The Health Plan has also partnered with behavioral health providers through the Behavioral Health Advisory Committee to seek input from the community to improve program administration.

UniCare recognized the opioid epidemic in West Virginia and identified Project ECHO® (Extension for Community Healthcare Outcomes) as a best practice model. Project ECHO, which launched in June, trains PCPs in rural and underserved areas to treat individuals with complex conditions, including opioid disorders. UniCare reached out to the ECHO organization in New Mexico and then approached the WVU School of Medicine about starting an ECHO around opioid disorder treatment. UniCare provided financial support as well as project management for the project. Project ECHO® will expand the WV ECHO program to MAT with community health centers, primary care, other physicians, and behavioral health providers. This is an expansion of the successful pilot program that features video-conference sessions between the primary care team responsible for MAT and the addiction specialist team from the Department of Behavioral Medicine and Psychiatry. The addiction specialist, infectious diseases specialist, addiction therapist, and care manager provide consultation on both patient cases and program policies and processes raised by the health center staff.

UniCare also implemented a prior authorization process in January 2017. Members receiving more than

50 morphine milligram equivalent (MME) per month require the prescriber to obtain a prior authorization. UniCare offers the Controlled Substances Utilization Program where members are targeted if they fill three controlled substances scripts by three different prescribers in three months. Prescribers that are identified in this program receive an educational letter to increase awareness and encourage coordination of care for these members.

WVFH has partnered with Beacon Health Strategies (Beacon) to coordinate members through a continuum of substance use treatment ranging from detox to residential care, to inpatient to traditional outpatient, providing medication assistance treatment whenever available for individuals with opiate addictions. Given the dearth of Suboxone programs, Beacon encourages members to consider Vivitrol (Naltrexone) as a treatment option, working closely with WVFH to provide case management on all individuals authorized for Vivitrol.

WV Project ECHO

WV Project ECHO - Medication Assisted Treatment

Helping the opioid epidemic

Through telementoring, ECHO provides local communities with access to high-quality specialty care.

Hub and spoke knowledge-sharing networks create a learning loop:

- Community providers learn from specialists.
- Community providers learn from each other.
- Specialists learn from community providers as best practices emerge.

- WV Project ECHO - Medication Assisted Treatment offers community health centers the opportunity to receive no-cost training in opioid addiction treatment.
- Weekly sessions connect healthcare providers with subject matter experts in addiction, infectious disease, therapy, and case management.
- Participants will also have the opportunity for in-person follow-up consultations with addictions specialists in the West Virginia University Department of Behavioral Medicine and Psychiatry's Comprehensive Opioid Addiction Treatment (COAT) program.

HEALTH PLAN OUTREACH AND EDUCATION

MCOs Offer Extensive Health Education Programs

The 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

Aetna's Member Newsletter includes important information for members such as immunization reminders and the importance of screenings such as Pap tests and mammograms. Additionally, Aetna conducts monthly outreach events through participation in health fairs or read aloud events. Aetna'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. Aetna 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. Aetna'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 PCPs 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. In addition to targeted mailings, the HEDIS team performs telephonic outreach to members in need of preventive services. Member incentives are available for successful completion of various preventive care visits. Aetna also partners with practitioner sites throughout the State to offer well-visit clinics targeting children and adolescents who are due/or late for their annual well-visit and immunizations. Aetna outreach and/or quality staff members are onsite during the well-visit clinics to provide member education as well as to provide the incentive gift cards for completing the visit. Aetna's most recent partnership is with Bonnie's Bus to provide mammography screening to members in high risk/underserved communities.



The Health Plan offers an array of preventive health interventions to help decrease the progression of illness and chronic disease. The Health Plan 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 in-

vited to attend any of several community flu clinics and health fairs at various locations throughout the state. In addition, The Health Plan employs member advocates, who conduct outreach calls to members to complete medical assessments and to 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. PCPs are sent a copy of items discussed so that they can follow up with members.

UniCare uses a strategy of mailing, text messaging, and direct member outreach (e.g., plan representatives calling members) to inform members about a variety of preventive health measures including lead screening, childhood immunizations, cervical and breast cancer screenings. To improve prenatal care, UniCare has partnered with community-based organizations throughout the state to launch baby showers and expand outreach efforts. Through a community program of presentations, crafts, and games, parents and children who attend receive health education on topics such as physical activity, nutrition, oral health, and weight control. 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.

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 by a navigator 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 has 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 Portal also provides a member access to a large

selection of written education and videos to assist them in managing their health. The WVFH website contains wellness brochures on topics such as dental care, pediatric vision, exercise and activity, substance use, medication safety and smoking cessation. Members may self-refer to WVFH wellness coaches including a registered dietician nutritionist, certified diabetes educator, and certified rehab counselor through the Member Portal. Member incentives are available for receiving well care from infants to adults. WVFH also offers the Growing Up Program to pediatric members, which provides services for members less than 21 years of age including screenings and vaccinations. The program aim is to find any health problems early and to continue routine monitoring to ensure children stay healthy. A 24/7 nurse advice line is available to all WVFH members in addition to quarterly member newsletters. The newsletter includes a vast array of information, which can include tips on staying healthy, preventative health guidelines, disease management programs, information about the transportation program and nurse line, and healthy recipes.

Nutrition, Physical Activity, and Weight

Aetna 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. The MCO 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 Aetna member encounter data information, and typically includes topics and related resources as



sociated with well-child health visits, immunizations, and prenatal care. During outreach events at health fairs, schools and community events across the State, Aetna provides information regarding healthy eating and the importance of exercise. The Outreach team also features a Wii system at many events with programs such as “Just Dance.”

The Health Plan 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. The Health Plan provides school- and employer-based health and wellness training modules. On-site clinics and wellness activities are also held at schools. A healthy snack program has been implemented by The Health Plan, focusing on healthy choices and encouraging physical activity through the use of a nationally recognized jump rope team.

MCO Asthma Efforts Improve Quality of Life

One MCO offers an asthma camp for children 8 to 13 years of age, where counselors teach self-management skills. An MHT member reported that her 13 year old granddaughter attended the camp. When she returned, the camper was able to show her grandmother how to use the optichamber and peak flow meter. The pair continue to successfully manage their asthma together with the help of the MHT program.

– THP

UniCare offers eligible members assistance with weight management issues through Weight Watchers and gym vouchers to Anytime Fitness & YWCAs. The UniCare website offers a variety of educational and informational articles pertaining to weight management, healthy eating, remaining

active, and healthy lifestyles. UniCare has collaborated with School Based Health Centers to encourage well child exams and weight and nutritional counseling for youth and adolescents. Through a promotion known as the “Well Child Contest,” school based health providers and sponsoring agencies receive additional reimbursement for completing well child exams that meet the national EPSDT criteria as well as the criteria established for weight, nutrition, and physical activity counseling. The center with the highest quality score earns \$2,500 for its school. Additionally, providers who reach the quality threshold for compliant exams are entered to win an additional \$5,000.

WVFH provides information related to exercise and activity through its member website and Member Portal. 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 a vital component of case and disease management activities. WVFH members have access to a licensed dietician to support their efforts towards a healthy lifestyle, and they are also provided information as needed on available resources and food banks in their area from the community repository. WVFH pediatric members receive education regarding healthy eating, physical activity, and reducing screen time from the Ways to Enhance Children’s Activity & Nutrition (WeCan) Program. WeCan is a national movement designed to give parents, caregivers, and entire communities a way to help children ages eight to 13 maintain healthy weight.

Tobacco Cessation

Aetna offers telephonic smoking cessation interventions with a tobacco cessation facilitator on staff, a contracted Smoking Cessation vendor, First Choice, 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.

Likewise, **UniCare** offers tobacco cessation assistance to members through resources including

the 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. Members have unlimited cessation counseling sessions at provider offices; the UniCare website offers information and education regarding smoking cessation, pregnancy and smoking, avoiding secondhand smoke, and more. As a value added benefit, members can receive a mobile phone that provides complimentary access to care with providers, the Quit Line, MedCall (the 24-hour nurse advice line), and UniCare customer service.

The Health Plan 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 The Health Plan who have been trained as American Lung Association facilitators.

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.

MCO 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 2016 all four plans participated in collaborative performance improvement projects (PIPs) to improve health outcomes and enrollee satisfaction.

The Diabetes Collaborative Performance Improvement Project

As mentioned, diabetes is a primary concern for the health of the state and the Medicaid population, in particular. Between 1996 and 2012, the prevalence of diagnosed diabetes nearly tripled in West Virginia. BMS has identified a need for targeted efforts in this area and, in response, has asked the External Quality Review Organization (EQRO) to

coordinate an effort with the MCOs to reduce the number of members with diabetes who have uncontrolled hemoglobin levels. The program is now in its third and final year. It has demonstrated success, with each health plan implementing its own MCO-specific interventions.

Aetna has created monthly Provider-Gaps-in-Care Lists to identify missed tests, screenings, and services. They also utilize a system to identify MCO members who are low, moderate, and high-risk diabetics as well as diabetic members who had three emergency room visits in a six-month period. Once identified, the Complex Case Management team and the Disease Management call center contact those identified, provide referrals, and distribute quarterly educational mailings.

The Health Plan has adopted HEDIS certified software to educate providers about diabetic services for members. The software has enabled the MCO to pinpoint members who are missing important services and help connect them to the correct resources. The Health Plan also operates a Wellness and Health Promotion (W&HP) Call Center that provides personalized contact with diabetic members. During each call, MCO staff educate members about the importance of preventive services for diabetes.

UniCare conducts live outreach phone calls to members to encourage them to get the services they need. UniCare experienced an increase in the number of members completing HbA1c tests and retinal eye exams for the third consecutive year.



Despite the increase, neither measure improved significantly. In an effort to promote effective diabetes care, UniCare has nurse coaches who assist members with adherence to physician plans of care, while providers block appointment slots for patients to improve access and availability.

WVFH offers a personalized mailer to members, detailing diabetes test results for HbA1c, LDL-C, dilated eye exam, micro albumin, and blood pressure. If members have not completed the appropriate tests, case managers are available for personalized assistance in scheduling appointments. WVFH also offers diabetes education and member rewards for diabetes self-management. As a result, the MCO saw an increase from 2015 in the HbA1c Control measure.

Prenatal Behavioral Health Risk Assessment and Postpartum Performance Improvement Project

All four MCOs participate in the Prenatal Behavioral Health Risk Assessment and Postpartum Performance Improvement Project, which aims to improve the postpartum care visit rate for pregnant women enrolled in the MHT program.

The MCOs conducted efforts to improve the postpartum care visit rate for pregnant women enrolled in the MHT program:

- The MCOs inform members of free transportation through member mailings, phone calls, and health plan websites.
- All four MCOs offer member incentives for practicing healthy behaviors and obtaining postpartum care services.

Each MCO has coordinated with a pilot site where discharge planners schedule postpartum care (PPC) visits with enrollees. To address transportation concerns for these PPC visits, Aetna provides newsletters, brochures, and other documents that inform members about free transportation. Aetna also offers incentives, both to providers and members. If members complete their PPC visit within 21-56 days after delivery, they receive a \$50 gift card.

Likewise, **The Health Plan** informs members about the availability of free transportation to PPC visits through prenatal and new member welcome calls. For pregnant members who obtain a qualifying prenatal visit in the first, second, or third trimester as well as a postpartum exam, The Health Plan offers an incentive.

UniCare increases awareness of no cost transportation to PPC visits through the plan's website, the member handbook, and maternal postpartum outreach calls. Additionally, UniCare requests Prenatal Risk Screening Instrument forms from providers during the prenatal period for all members. Like the other plans, a financial incentive is offered to members for attending the PPC appointment.

WVFH relies on prenatal packets as a mechanism to disseminate information about free transportation for members. Their GTLM Mom Matters Program proactively identifies expectant mothers in a multidisciplinary, continuum-based holistic approach. If members attend their PPC visit within the 21-56 day window, they are rewarded with a \$50 gift card.

Other Performance Improvement Projects

While the Diabetes PIP and the Prenatal Behavioral Health Risk Assessment and Postpartum PIP are required for all MCOs, the MHT health plans have some flexibility in designing the third PIP. Each MCO has focused on specific subgroups to encourage healthy behaviors.

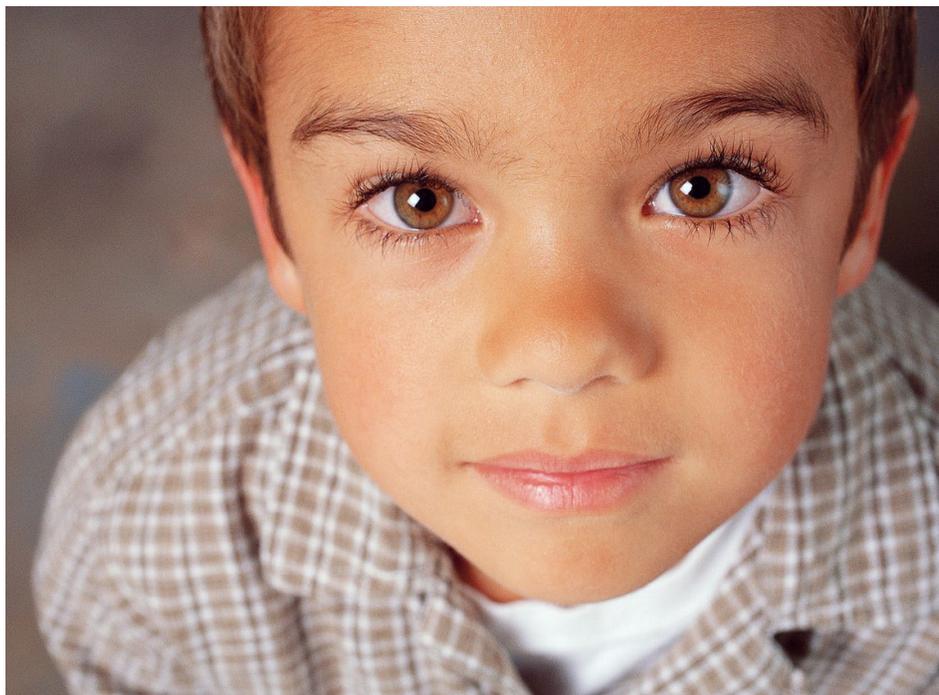
Aetna's Annual Monitoring for Patients on Persistent Medications Performance Improvement Project is designed to improve the rate of monitoring for members who are over the age 18 and taking an ACE/ARB, diuretic, or digoxin. Aetna uses Provider Gaps-in-Care Lists to help providers identify members who were non-compliant for recommended screenings.

The Health Plan strives to increase Adolescents Well-Care Visit and Well-Child Visit rates during the third, fourth, fifth, and sixth years of life. Through their W&HP Call Center, outbound specialists help members to get established with their

PCP; this simultaneously reduces ER and walk-in clinic utilization. The Health Plan's incentive program for members with a qualifying well-visit claim continues to encourage members to obtain routine and preventive services.

UniCare began a new initiative this year working to improve the rate of follow-up for members after hospitalization for mental illness. One intervention has proven to be very robust with UniCare contacting 100% of members discharged from inpatient admission for mental illness and offering case management services. UniCare's rate of follow-up after hospitalization for mental illness (30 days) among their members significantly increased as a result.

WVFH directed their efforts towards improving the rate of well-child visits for children age three to six. As part of their Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life Performance Improvement Project, WVFH emphasized health dialog, providing patients with 24/7 telephone access to healthcare professionals. The MCO also holds trainings for care managers and outreach nurses based on new EPSDT protocols, reward programs, and changes to evidence-based clinical guidelines. The rate of well-child visits increased; however, the improvement was not statistically significant.



COST SAVINGS

The MHT 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 FFS Medicaid. In addition to medical savings, there are administrative efficiencies.

In SFY 2017, there was an increase in MCO pharmacy costs which impacted the savings achieved through managed care. As a result, the managed care cost was slightly higher than the estimated FFS equivalent. A comparison study was conducted, and it was estimated that pharmacy costs would be less under FFS. The pharmacy benefit was then moved from the MCOs to FFS effective July 1, 2017.

SFY 2017 Estimated MHT Program Total Savings Including Pharmacy

	Fee-for-Service (FFS)*	MHT
Member Months	4,886,317	4,886,317
Average Number of Members Per Month	407,193	407,193
Medical/Capitation per Member per Month	\$322.67	\$335.07
Total Medical/Capitation Spending	\$1,576,687,883	\$1,637,274,621
State Administrative Costs	\$63,067,515	\$8,186,373
Total Spending	\$1,639,755,398.43	\$1,645,460,994.35
SFY 2017 Total Savings for MHT		(\$5,705,596)
Percent Savings over FFS		-0.3%

Excluding MCO pharmacy costs, the MHT program still achieved savings of approximately \$22 million in combined federal and state funds, compared to the costs of covering the same population through FFS. This reflects the addition of the SSI population to managed care effective January 1, 2017.

SFY 2017 Estimated MHT Program Total Savings Excluding Pharmacy

	Fee-for-Service (FFS)*	MHT
Member Months	4,886,317	4,886,317
Average Number of Members Per Month	407,193	407,193
Medical/Capitation per Member per Month	\$218.68	\$221.72
Total Medical/Capitation Spending	\$1,068,554,576	\$1,083,388,316
State Administrative Costs	\$42,742,183	\$5,416,942
Total Spending	\$1,111,296,759.05	\$1,088,805,257.20
SFY 2017 Total Savings for MHT		\$22,491,502
Percent Savings over FFS		2.0%

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

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 MHT 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 ED 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 2017, BMS reviewed the results of the 2016 member survey, based on the nationally-accepted 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. For measures that fall below the national benchmark, MCOs are required to implement corrective action plans and evaluate intervention efforts on an annual basis.

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 health plan, doctors, and care. Over 84% of parents of children enrolled in MCOs responding to the survey gave their MCO an overall rating of eight or higher using a zero to ten scale (where zero is the "worst possible" and ten is the "best possible"). In addition to their satisfaction with their programs overall, parents reported high satisfaction in a number of areas. This exceeds the national Medicaid average.

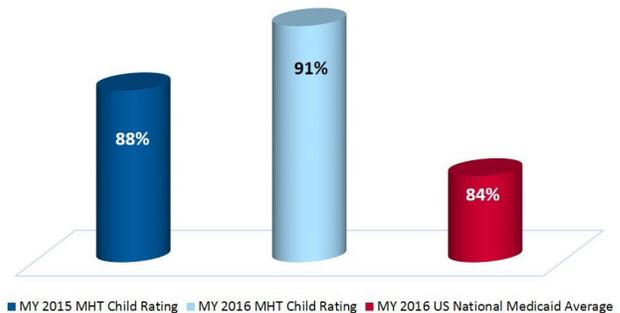
A vital element of health care is the ability of members to access care when needed. Among survey respondents, 95.7% of parents of children enrolled in an MCO reported that it was "always"

or "usually" easy for their child to quickly get the care, tests, or treatment he or she needed. This exceeds the 90th percentile (93.6%).

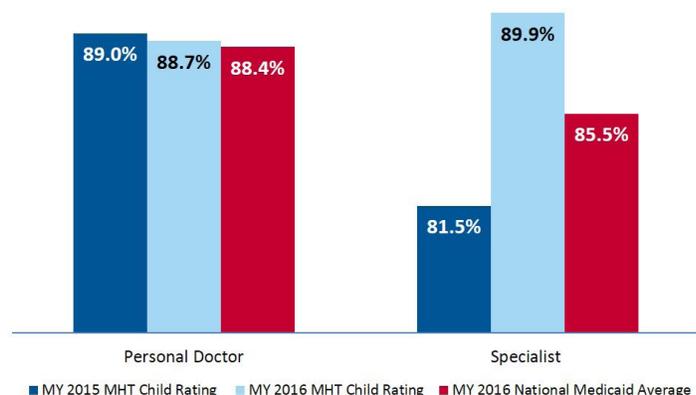
The following charts reflect quality scores using measurement year (MY) 2016. The measurement year is the period from which data was collected to calculate the measure rates. Rates for MY 2016 reflect MCO performance between January 2016 and December 2016.

For several other key indicators in the child survey, including satisfaction with a member's personal doctor and satisfaction with a member's most commonly seen specialist, ratings for the

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 (MY 2016)



Parents were satisfied with their children's personal doctor & specialists in MY 2016



MCOs exceeded the national Medicaid averages among members who responded.

High Satisfaction Reported for Adults

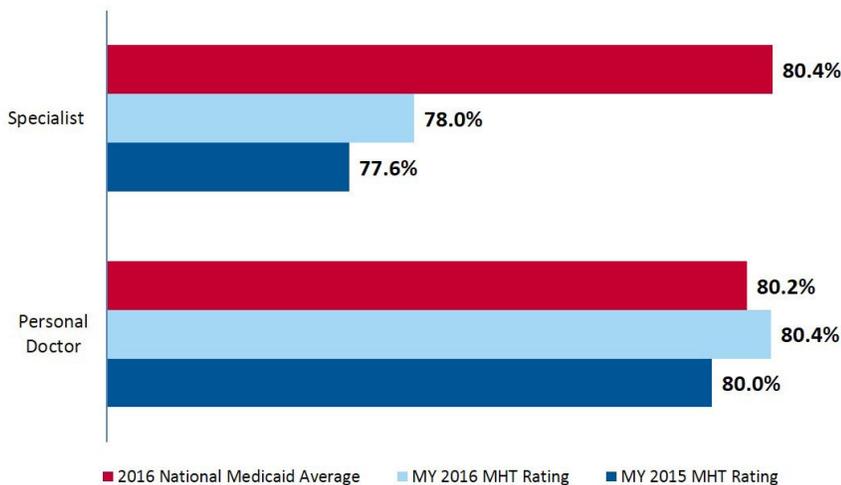
Similar to parents of enrolled children, the majority of adults in the MCOs were satisfied with their health plan, doctors, and overall care. Enrolled adults rated their personal doctors highly; 80% of adult survey respondents gave their personal doctor a rating of eight or above (on a scale of zero to ten), which is the same as the national average. Access to specialists is expected to be slightly lower, since West Virginia is a state with many rural areas, and the number of specialists available to all state residents is limited.

Adult survey respondents also reported satisfaction with their ability to both receive care when needed and receive timely care. 83.6% 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 75th percentile. Similarly, 82.5% of adults reported satisfaction in the timeliness of their care, exceeding the national Medicaid average.

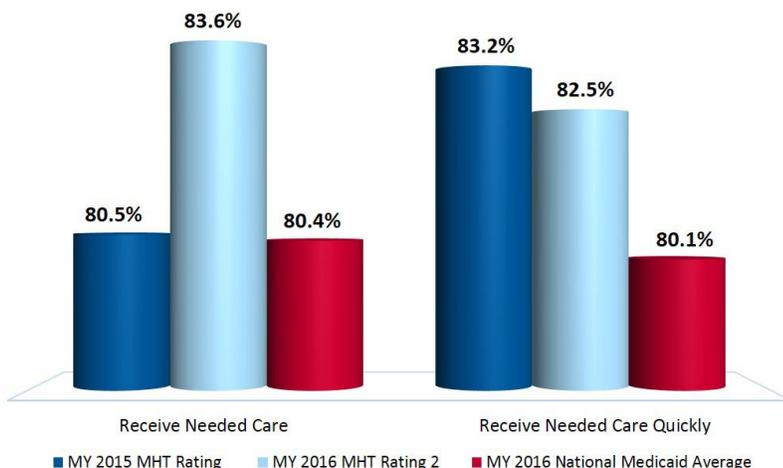
For areas in which the survey results demonstrated need for improvement, BMS has required the MCOs to implement action plans for improvement, including actions such as additional outreach to members and training for staff. The improvements focus on areas such as educating providers on cultural competency, 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 2017. BMS will continue to monitor the results of the survey to determine opportunities for improvement in the MHT program to provide the best quality of care possible.

Adults were satisfied with their own personal doctors & specialists in MY 2016



Adults were satisfied with both the access to and timeliness of needed care in MY 2016



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

BMS contracts with an independent EQRO, Delmarva Foundation, 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 MHT program standards outlined in 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 HEDIS to measure and validate MCO performance on quality, access, and timeliness of care indicators. HEDIS measures, maintained by the NCQA, are considered the gold standard for measuring performance and are used by over 90% 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 deliv-

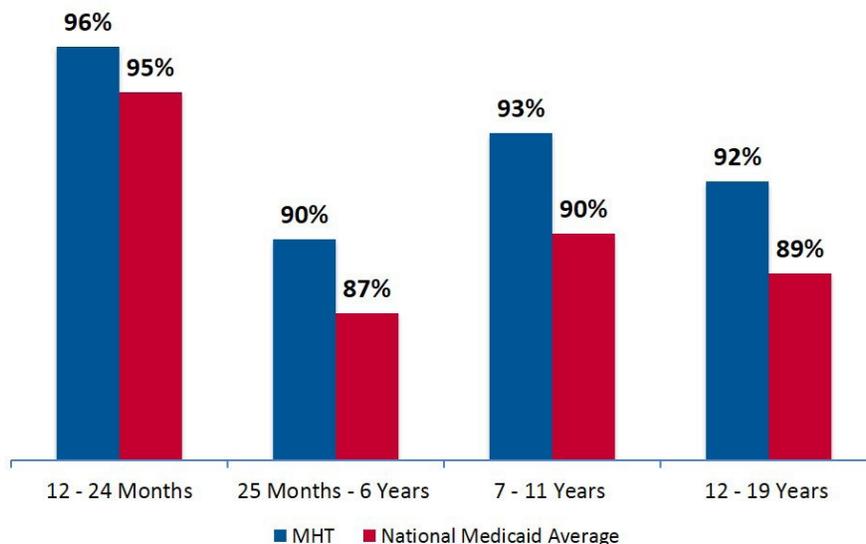
ering high-quality care. Thus, increasing rates of preventive care has been an important focus for the MCOs. HEDIS results for Calendar Year (CY) 2016, which is the latest year data is available, demonstrated that the vast majority

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 four MCOs exceeded the National Medicaid average for the percentage of children and adolescents with a PCP visit in the measurement year.

BMS is committed to increasing access to preventive and ambulatory health services for

They are “kind, nonjudgmental, and open and willing to help me.”
— Aetna member

For every age group of children and adolescents, the MHT average exceeded the National Medicaid average for the number of members with a PCP visit in 2016

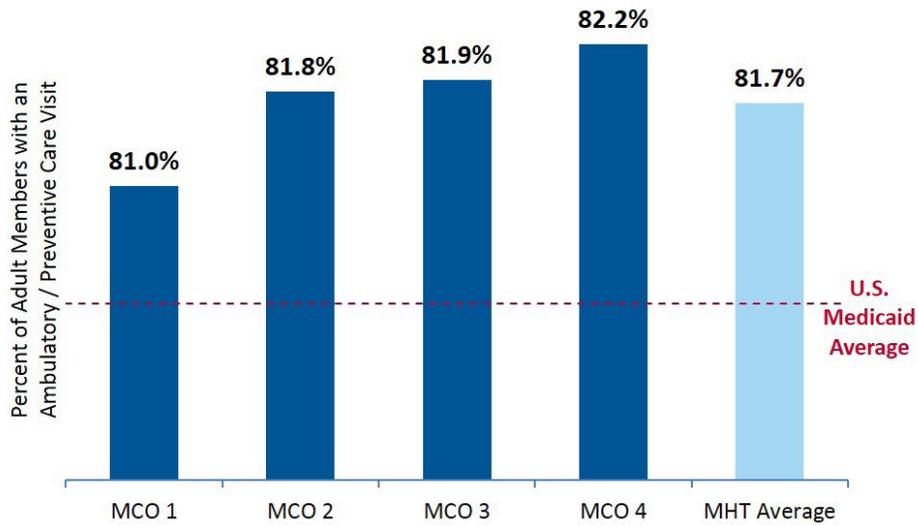


adults in the MHT program. Adult members in the MHT program also have high rates of preventive care, with four MCOs exceeding the National

Medicaid average. In 2016, the MHT average (81.6%) exceeded the National Medicaid average (80%).

MCOs Deliver Quality Care

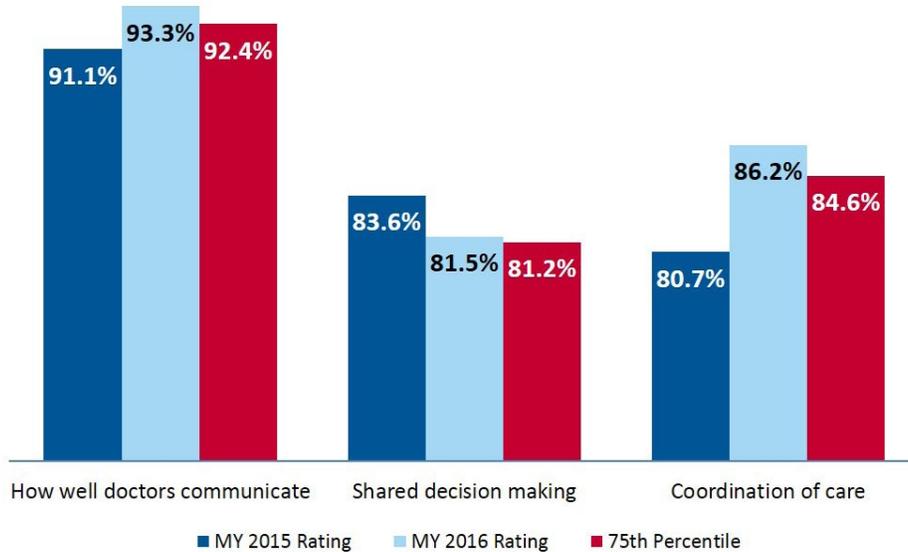
All four MCOs exceeded the National Medicaid average for the percentage of adult members with an ambulatory or preventive care visit in 2016



In MY 2016, the MCOs performed notably well in doctor-patient communication, shared decision making, and coordination of care. Ratings for how well doctors communicate (93.3%) and coordination of care (86.2%) improved since MY 2015 among survey respondents. While doctor communication, shared decision making, and coordination of care all exceeded the 75th percentile, MCOs continue to identify potential opportunities 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

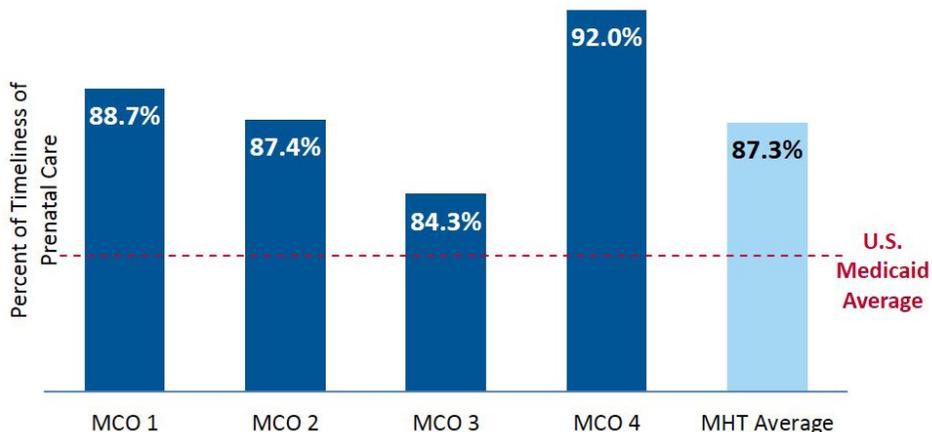
The MHT program exceeded the 75th percentile for doctor-patient communication, shared decision making, and coordination of care



several years. For 2016, all four MCOs reported rates of women receiving a timely prenatal care visit that were over 80%, and the MHT average for all four MCOs was 87.3%. Each MCO surpassed the National Medicaid average for women receiving timely prenatal care, 81.7%.

Administration of regular preventive screenings for children, known as EPSDT in Medicaid, is an important part of any health program. MHT places emphasis on increasing the number of children who regularly

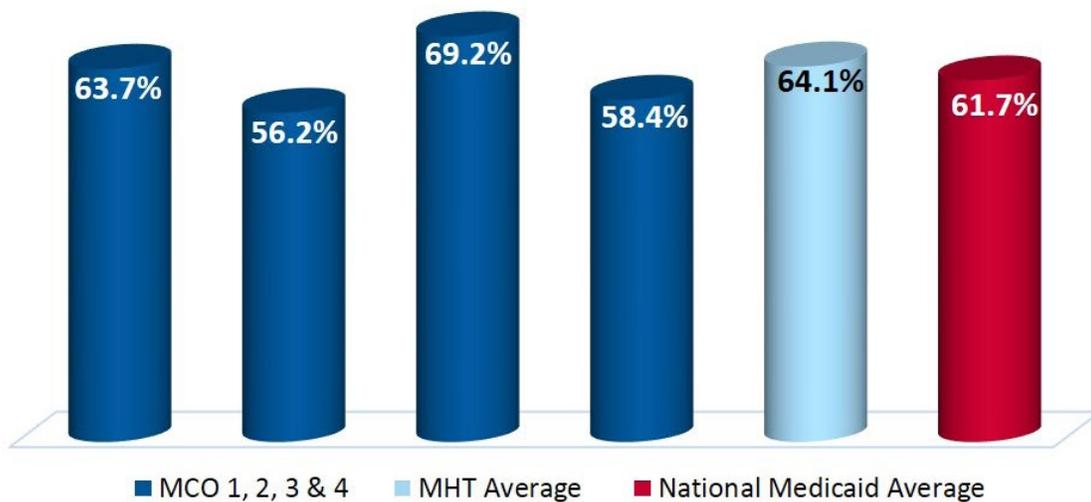
The MHT Program performed better than the National Medicaid average for timeliness of prenatal care in 2016



receive these services. BMS is committed to increasing the number of members receiving well-child visits 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 2016 MHT average (64.1%) is higher than the National Medicaid average (61.7%) for the percentage of members who received six or more visits during the first 15 months of life.

Two out of four MCOs 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 in 2016



MCO Member Services Centers are Responsive to Members

In addition to access to medical care, members are also able to seek help through MCOs' member services centers. This continues to be an area of focus for the MCOs and the plans worked to improve performance through:

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

MHT PROGRAM INNOVATION

BMS supports a value based health care system where member experience and population health are improved, health care costs are contained, and quality is continuously improved. To achieve this program goal, BMS has implemented several innovative strategies.

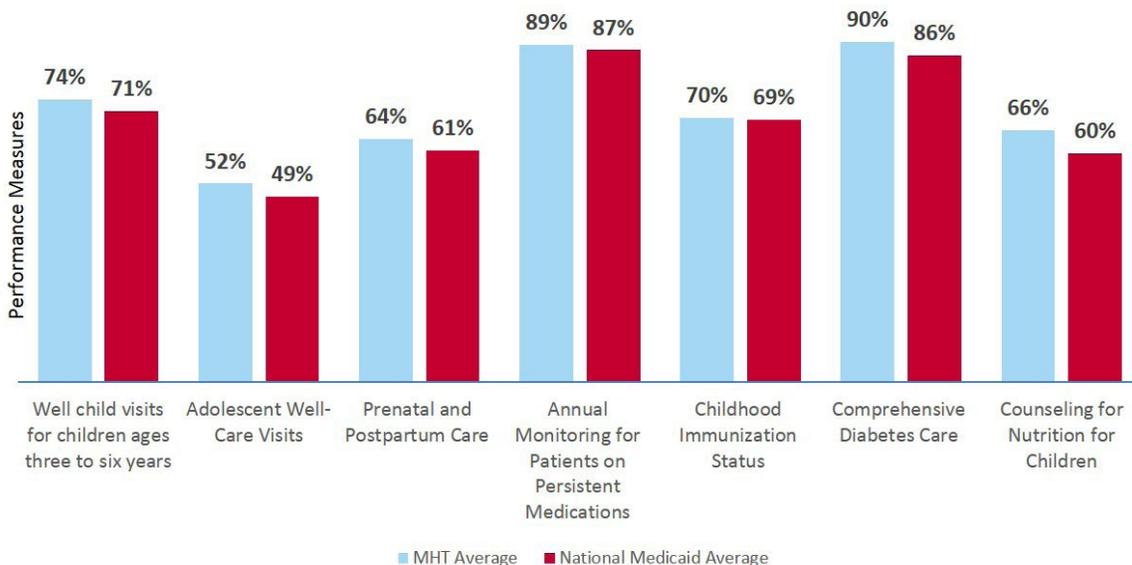
Performance Withhold

Beginning July 1, 2014, BMS put each MCO at risk for 5% of the MHT capitation payment by withholding that amount from the monthly MHT program capitation paid to the MCO by BMS. BMS's objective was for the MCO to achieve performance standards, enabling the MCO to earn the 5% withhold back. BMS identified no more than ten performance measures during the calendar year. These performance measures were based on the relevant MHT program goals with consideration of nationally recognized benchmarks, and promoted the goal of continuous improvement in the MHT program.

Annually, BMS evaluated whether or not the MCO had fully met the performance measures for which the MCO was at risk. BMS determined the extent to which the MCO had met performance measures by assessing each MCO's report relative to performance targets for the corresponding calendar year. The CY 2016 measures used in SFY 2017 were: well child visits for children ages three to six years; adolescent well-care visits; initiation and engagement of alcohol and other drug dependence treatment; follow up after hospitalization for mental illness; prenatal and postpartum care; annual monitoring for patients on persistent medications; medical assistance with smoking and tobacco use cessation; childhood immunization status; comprehensive diabetes care; and counseling for nutrition for children/adolescents.

All health plans received a significant portion of their withhold capitation funding. In SFY 2017, the withhold amount was reduced to 1%, but the MCOs continued to show progress in meeting the benchmarks. The combined average for the MHT program exceeded the targeted benchmarks for seven of the ten measures.

The MHT Program exceeded the targeted benchmarks in more than half of the measures in 2016



Alternate Payment Models

Beginning in July 2017, BMS required MCOs to implement alternate payment models (APMs) that shift from FFS reimbursement to reimbursement that rewards improved delivery of healthcare. Through aligned incentives, MCOs will design and implement APMs with provider partners. These models will be required to include 10% of members enrolled during the year and will tie reimbursement to measurable outcomes. APMs may include options such as primary care incentives, shared savings arrangements, bundled payments, and risk sharing arrangements.

Aetna already offers multiple value-based provider reimbursement models that may be uniquely structured to meet the needs of the provider's practice, geographical location, or population served. Current Aetna value-based provider contracts include:

- A shared risk, capitation agreement with a large hospital provider that covers over 12% of the ABHWV Medicaid membership;
- A Pay-4-Performance contract with one of the largest provider partnerships within the West Virginia market. The provider partnership includes provider groups from primary care, specialists, behavioral health providers, and federally qualified organizations; and
- A Patient Centered Medical Home (PCMH) agreement with one of the largest multi-specialty, university groups that covers over 5,000 ABHWV members.

In addition, Aetna offers certain contracted providers the opportunity to participate in "upside only" initiatives that focus on improving specific quality metrics within a short focus period of time.

The Health Plan is developing an innovative approach to providing an APM throughout their service area. The MCO has been able to utilize multiple years of financial data as well as three years of clinical based analytic data to develop a plan that addresses alternative payment mechanisms, while providing a measurable results oriented ap-

proach to improve the health outcomes for their covered population. The program, scheduled to begin in January 2018, is structured on a medical home concept; however, the foundation is centered on providing the provider base a "care intensity index" on each member assigned to the respective primary care unit. In addition to an established base reimbursement, the care intensity level will provide an adjustable per member per month management fee during the inception. Included in the model will be an annual bonus opportunity based on a variety of measures that can be tracked real time throughout the year as well as a risk based option for qualified potential partners.

UniCare offers a shared savings program, known as the Provider Quality Incentive Program (PQIP), to eligible PCPs. For the 2017 PQIP program, 24 PCPs participated in the program. Using a system of quality measures and pay-for-performance principles, PQIP seeks to encourage efficient, preventive and cost-effective health care practices. The main objectives of PQIP include: improving targeted clinical quality results; promoting quality, safe and effective patient care across the health care delivery system; improving provider operational efficiency; improving medical cost management by providing primary care providers with incentives for improving quality of care and by providing population health management tools to providers to assist them in reducing unnecessary utilization and costs. PQIP providers who meet quality benchmarks and improvements as well as medical cost management targets receive shared savings payments.

WVFH currently has care management models in place with key Medicaid providers in the market. These include university partners who have already expanded care management. Additionally, to address the new requirements for APMs, WVFH will be working to expand efforts with Federally Qualified Health Center (FQHC) partners who treat WVFH members. The plan includes enhanced reporting and partnered care coordination with the FQHC staff who handle these patients daily. Future APM approaches will include other provider incentives directed at proven and relevant quality measures.

LOOKING AHEAD FOR THE MHT PROGRAM

In SFY 2017, the MHT program saw significant growth and improvement. BMS plans to continue these efforts in SFY 2018. The addition of the SSI population to managed care in January 2017 drove a portion of program growth. Likewise, the behavioral health and pharmacy benefit were transitioned into managed care effective SFY16, while the children's dental benefit was added January 2014. With the recent addition of the ACA Medicaid Expansion population, BMS remains dedicated to enrolling all eligible individuals in the MHT program. BMS will continue working with the enrollment broker, Maximus, and the MCOs to conduct outreach and enrollment activities throughout the entire state. Individuals and families will receive information about their MCO choices, the enrollment process, and a guide to using the MHT program.

As always, BMS continues 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 MHT program. BMS has increased coordination with other West Virginia DHHR bureaus, particularly the Medicaid Fraud Control Unit, to identify and combat fraud, waste, and abuse in the Medicaid program. BMS is employing new mechanisms to drive greater improvements in quality of care and accountability that will be incorporated into the SFY 2018 managed care contract.

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



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