West Virginia Medicaid
Mountain Health Trust

Annual Report

State Fiscal Year 2024
(July 2023 - June 2024)

September 30, 2024

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 preventive 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)

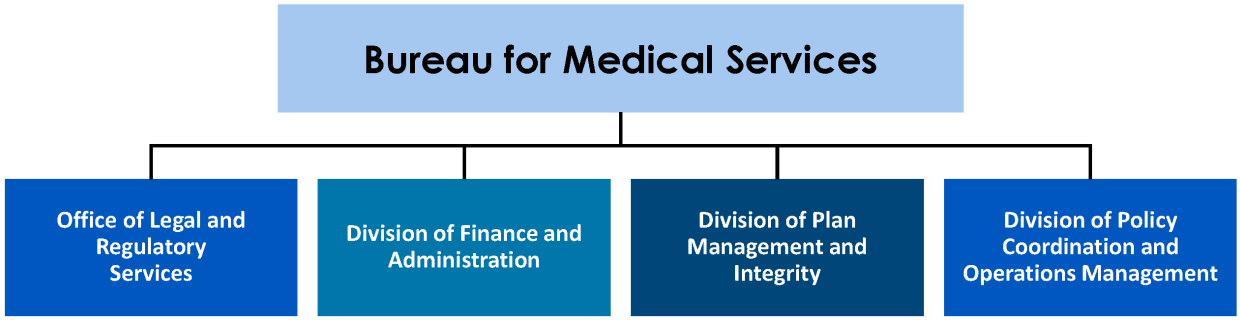
DoHS is the State's organization responsible for supplying a wide range of health care services necessary for the residents of West Virginia. DoHS's mission is to promote and provide health and human services to the people of West Virginia in order to improve their quality of life and health outcomes. 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 Division of Plan Management and Integrity monitors and oversees the Mountain Health Trust (MHT) program.

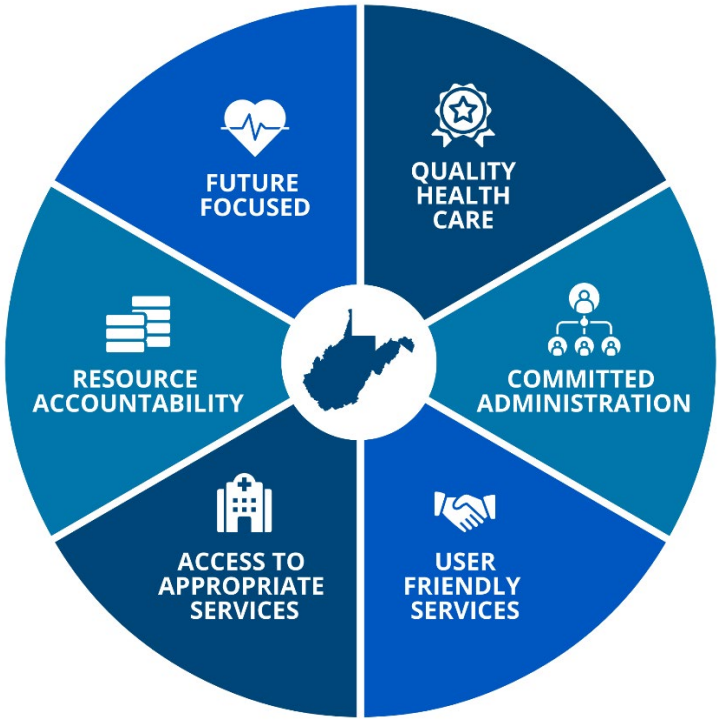
Figure 1: BMS Organizational Structure



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 meet to advise BMS on a range of issues, including providing feedback on 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 program (e.g., enrollment, health care delivery, external monitoring, etc.).

Mountain Health Trust (MHT)

Program Overview

The MHT program provides essential health care coverage to children and adults with low income and eligible individuals with disabilities. Covered members include children and their parents or other caretaker relatives, adult Medicaid expansion members, pregnant women, and qualifying individuals receiving SSI. West Virginia expanded coverage to low-income adults under the Affordable Care Act Medicaid expansion option and integrated these members into the MHT delivery system.

The MHT program was implemented in 1996 as the State's first risk-based managed care program. MHT was established under Section 1915(b) waiver authority of the SSA of 1981.[2] Every two years, states are required to renew their 1915(b) waivers and report program monitoring results to CMS for the prior waiver period.

West Virginia has Title XXI State Plan authority for the West Virginia Children's Health Insurance Program (WVCHIP). WVCHIP members received benefits through the Public Employees Insurance Agency (PEIA) until July 1, 2021, when BMS shifted service delivery for these members into managed care. As of July 1, 2023 (state fiscal year 2024 [SFY24]), BMS integrated WVCHIP into the MHT program. WVCHIP adopted the Medicaid benefits package for medical, behavioral health, dental health, and pharmacy services. Over 24,400 children under the age of 19 and pregnant women are enrolled in WVCHIP.

For the MHT program, BMS contracts with three managed care organizations (MCOs) to provide services to enrollees. Those MCOs are Aetna Better Health of West Virginia (ABHWV), The Health Plan of West Virginia (THP), and UniCare Health Plan of West Virginia. Visit the following MCO websites to view covered services under the MHT program:

- Aetna Better Health of West Virginia.
- The Health Plan.
- UniCare Health Plan of West Virginia.

In October 2023, BMS issued a Request for Application for qualified MCOs to provide services for the MHT program. Highmark Health Options West Virginia (HHOWV) was selected to provide statewide physical health, behavioral health, and dental services for eligible Medicaid and WVCHIP members. Members can enroll in HHOWV starting August 1, 2024.

MHT Enrollment and Demographic Information

As of July 1, 2024, MHT serves approximately 378,979 members.[3] Approximately half of the MHT program members are provided temporary assistance for needy families (TANF), followed by the adult expansion category, and SSI income category. Pregnant women and children's

[2] SSA of 1981, Sec. 1915. [42 U.S.C. 1396n].
[3] Managed Care Monthly Enrollment Report, July 2024.

special health care needs represent a nominal number (less than 1%) of enrolled members. Populations of less than 1% are not represented in *Figure 3*.[4]

Figure 3: MHT Enrollment by Eligibility Category

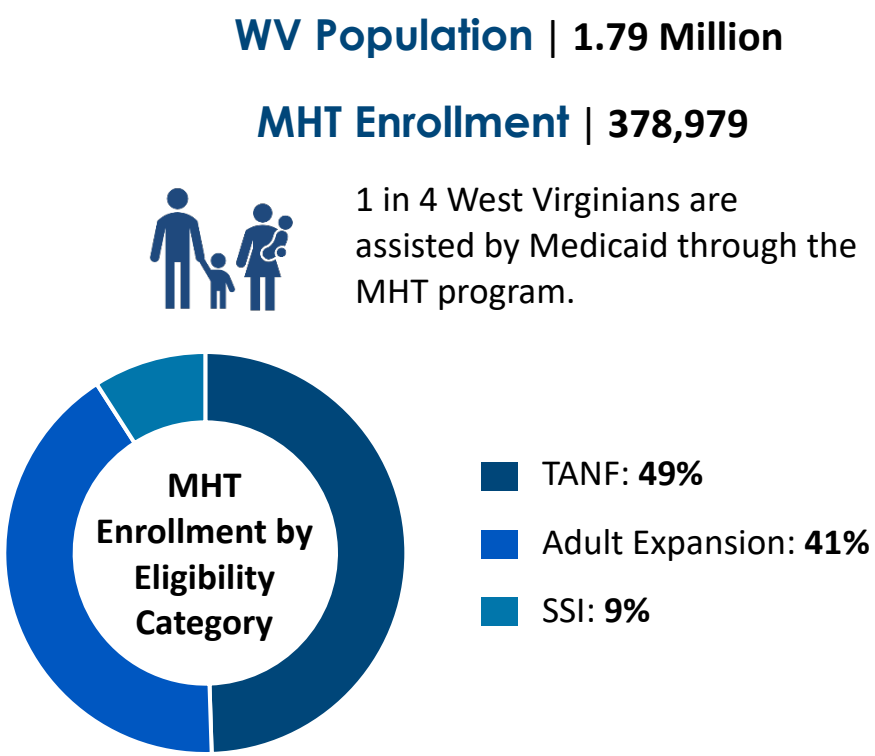
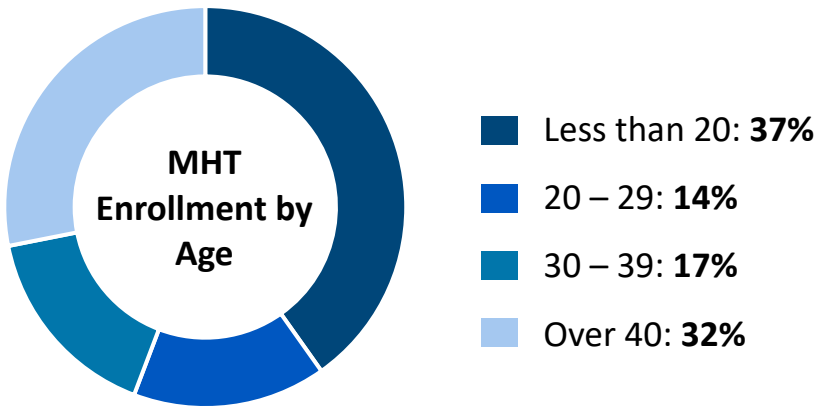
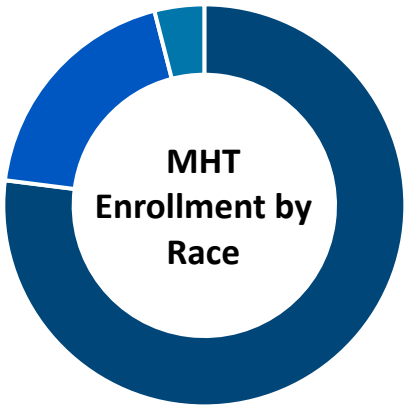


Figure 4 provides MHT program enrollee breakdown by the demographic categories of age, race, and ethnicity.[5]

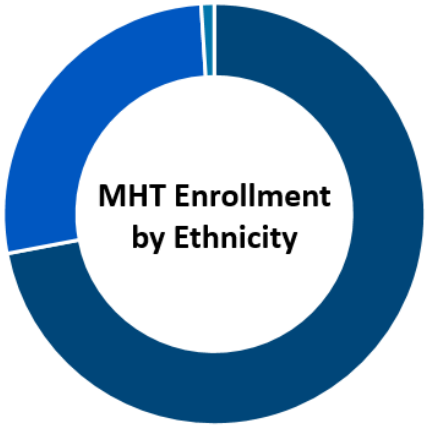
Figure 4: MHT Enrollment by Age, Race, and Ethnicity



[4] West Virginia Census and MHT encounter data through July 1, 2024, as of August 2024.
[5] West Virginia Census and MHT encounter data through July 1, 2024, as of August 2024.



- Caucasian: **77%**
- Other: **19%**
- African American: **4%**

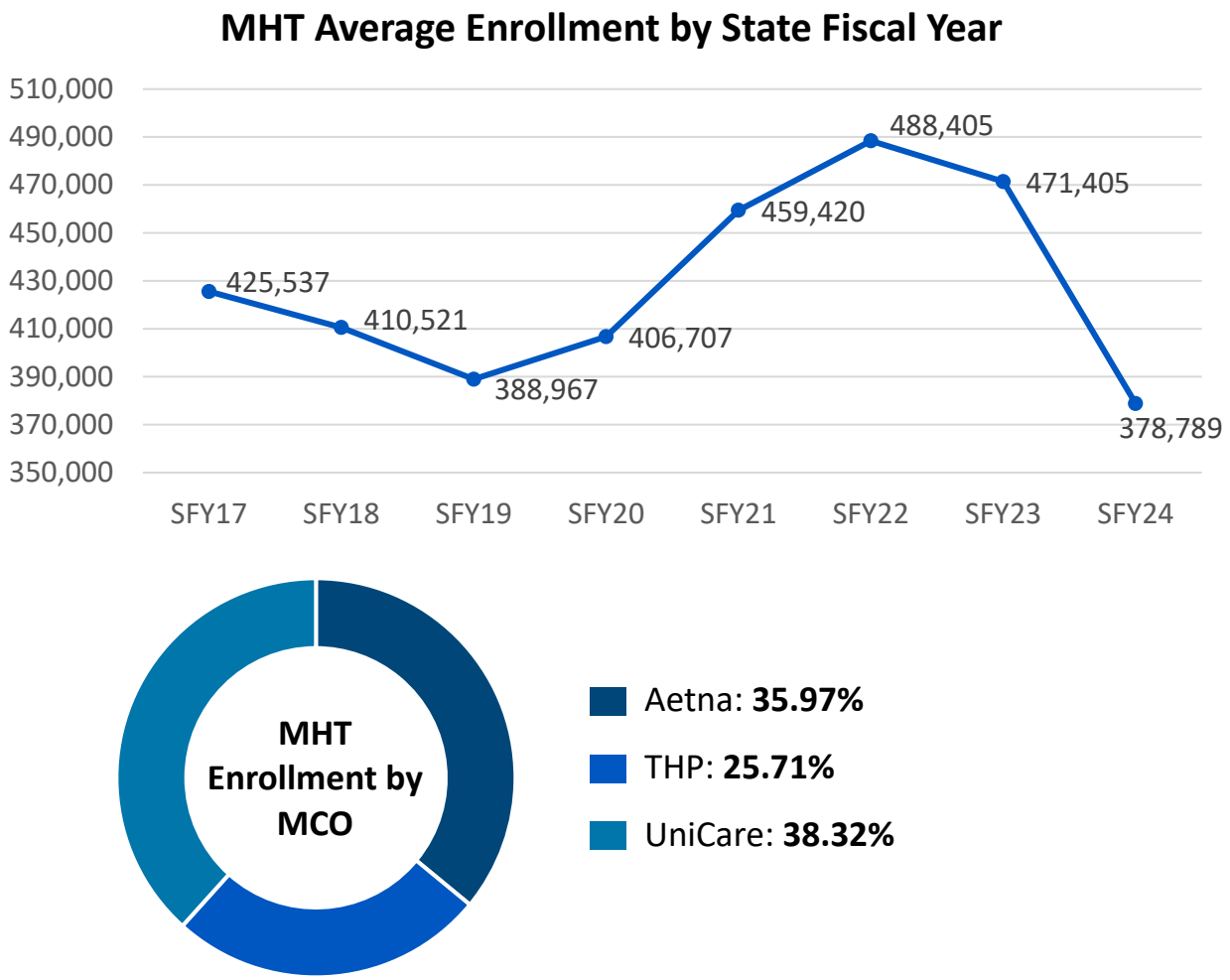


- Not of Hispanic or Latino Origin: **72%**
- No Response: **27%**
- Hispanic or Latino Origin: **1%**

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.*[6] shows the steady increase in the number of individuals enrolled in the program from SFY19 through SFY22, with a decline in average enrollment in SFY23-24.

[6] Data Sources: West Virginia Census and MHT encounter data through July 1, 2024, as of August 2024.

Figure 5: MHT Average Enrollment by State Fiscal Year and by MCO



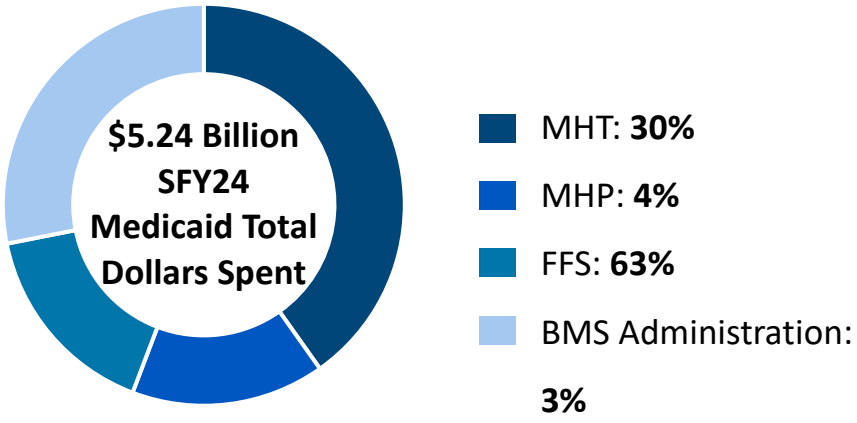
Program Expenditures

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 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 Mountain Health Promise (MHP) SFY24 expenditures (*Figure 6*) represent approximately 4% of the total federal and state spend. The MHT program totals approximately 30% of total dollars spent, while 63% is attributed to fee-for-service.

Figure 6: SFY24 Medicaid Spending

Spending	
$1.61 Billion Total MHT Expenditures in SFY24	MHT accounts for **30% of total SFY24 Medicaid Spending**

Spending	
85% federal dollars	15% state dollars
Total Federal Spend $1.37 billion	**Total State Spend** $239 million



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

Directed Payment Programs (DPPs)

Created through the 2016 Medicaid managed care rule, DPPs allow the State to require MCOs to pay providers according to certain rates or methods established or "directed" by the State. They allow the State to distribute funding and incentives to providers with the goal of improving health outcomes and enhancing health care delivery. States must submit proposed DPPs to CMS for review and approval to ensure they are within federal guidelines before implementation. These payment arrangements can include setting a minimum and maximum payment rate for specific types of health care providers, as well as value-based payment arrangements, which seek to advance the State's Managed Care Quality Strategy goals.

In SFY24, West Virginia's health care delivery system received approximately $343.9 million in hospital DPP, and $71 million through the Senate Bill (SB) 546 (provider specialist) DPP. The MCOs received several CMS-approved supplemental payments from BMS in SFY24, including:

- $21.5 million for school-based services.
- $14.8 million for direct medical education.
- $2.5 million for the Health Insurance Premium Payment Program.
- $.85 million for the critical access hospital settlements.

MCO Profiles

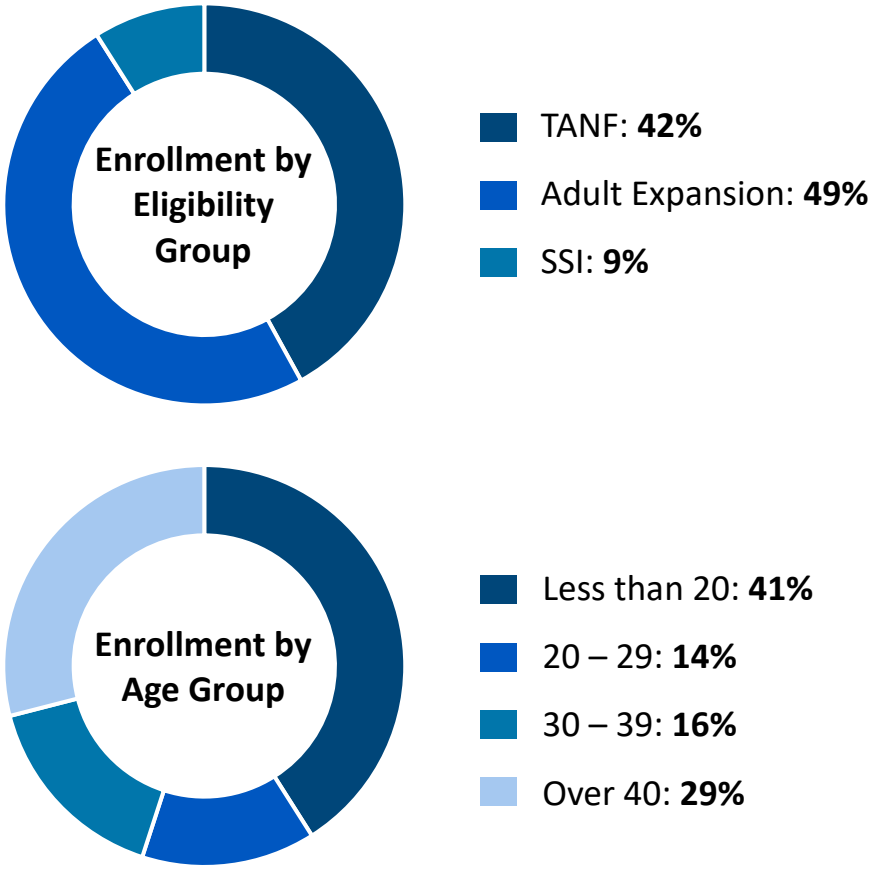
There are three contracted MCOs that have been serving Medicaid managed care members since the inception of the MHT program in 1996. MCOs are essential in the coordination of healthcare services and benefits while focusing on improving health outcomes for their members. The MCO profiles below provide MCO-specific enrollment details for the MHT program. Please note that populations of less than 1% are not represented.

Aetna Better Health of West Virginia (ABHWV)

Membership and Enrollment

As of June 2024, ABHWV had 136,237 total members, representing 35.97% of the MHT population. Enrollment by eligibility and age group are illustrated in *Figure 7*.[7]

Figure 7: ABHWV Enrollment by Eligibility and Age Group



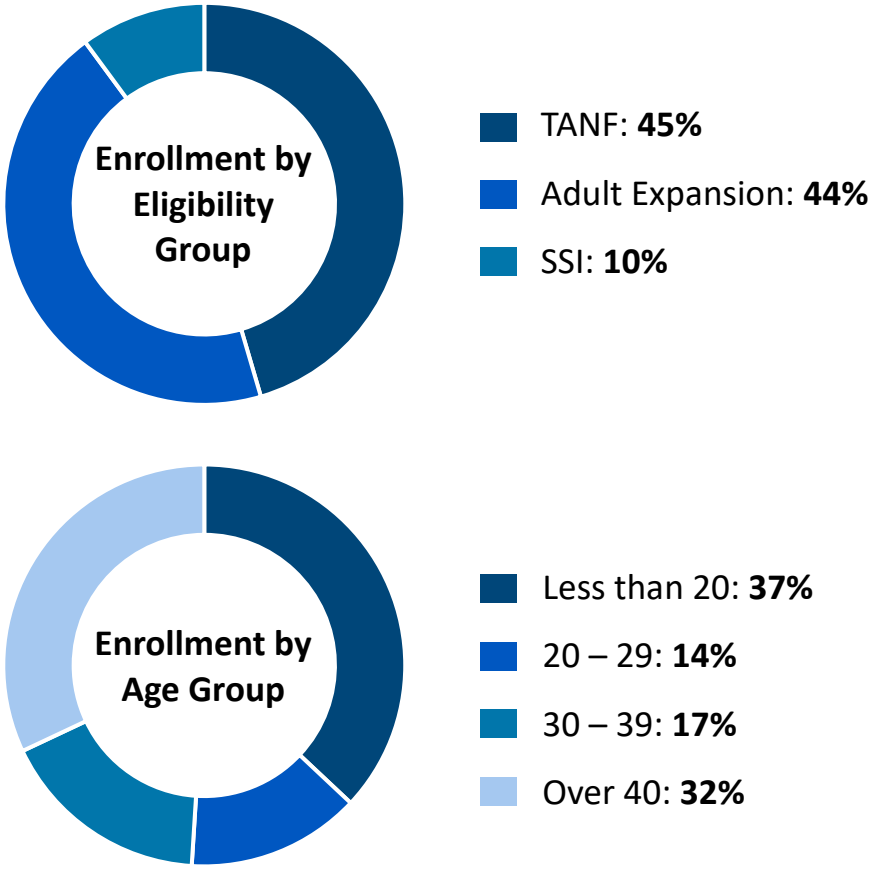
[7] Data Source: MHT Medicaid Management Information System (MMIS) data through June 30, 2024, as of August 2024.

The Health Plan of West Virginia (THP)

Membership and Enrollment

As of June 2024, THP had 97,382 total members, representing 25.71% of the MHT population. THP enrollment data is included in *Figure 8*.[8]

Figure 8: THP Enrollment by Eligibility and Age Group



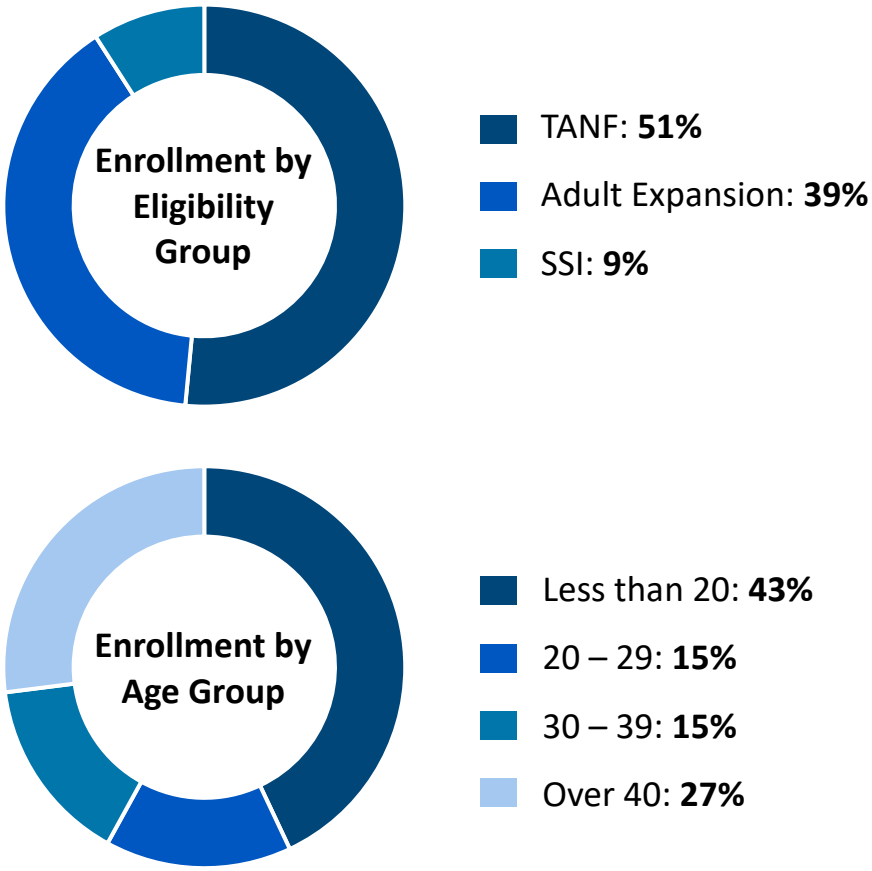
UniCare Health Plan of West Virginia

Membership and Enrollment

As of June 2024, UniCare of West Virginia had 145,170 total members, representing 38.32% of the MHT population. UniCare enrollment data is included in *Figure 9*.[9]

[8] Data Source: MHT MMIS data through June 30, 2024, as of August 2024.
[9] Data Source: MHT MMIS data through June 30, 2024, as of August 2024.

Figure 9: UniCare Enrollment by Eligibility and Age Group



MCO Community Support

In January 2021, BMS updated MCO contracts to enable MCOs to develop strategies and initiatives targeting social determinants of health (SDOH). SDOH encompass the conditions in the environments where people are born, live, learn, work, play, worship, and age, and they significantly impact health, functioning, and quality-of-life outcomes.[10] The SDOH includes factors such as housing, education, income, transportation, food security, employment/workforce development, education, childhood experiences, behavior, access to care, and environment. Addressing SDOH is especially important for Medicaid and WVCHIP populations to improve long-term health outcomes and reduce disparities.

The SDOH strategies are aimed at enhancing integrated physical and behavioral health care, promoting active local involvement, and focusing on enrollees and their families through proactive case management. MCOs must ensure that their strategies meet criteria for improving healthcare quality and include these expenditures in the medical loss ratio, which ensures that funds are spent directly on Medicaid enrollees.

[10] Bureau for Medical Services, Model Purchase of Service Provider Agreement.

Measure of Success: MCO Community Support

During SFY24, MCOs implemented various strategies to address SDOH including the following:

ABHWV

- Made an investment with Williamson Health & Wellness to assist with the re-opening of the Williamson Memorial Hospital facility, which will provide much needed acute care services for southern West Virginia.
- Provided financial support to Healthright Milan Puskar in Morgantown to re-open a homeless/warming shelter for the 2023-2024 winter months.
- Provided a grant to the Family Support Center Association which will provide each of the 56 state-based Family Support Centers with funding to enhance and improve the services they provide to local residents in their areas.

THP

- Established a Children with Special Healthcare Needs (CSHCN) value-add service to encourage families to apply/enroll in the State's CSHCN program so members could receive dual case management services from both THP and DoHS to help best meet the members' needs.
- Made investments in larger health care systems, including hospitals and federally qualified health centers (FQHCs), to provide programs such as mobile nursing labs and retinal cameras for diabetic imaging.
- Established a Food for Health program with local food pantries and three FQHC partners. The partnership allows 150 THP members with chronic conditions to receive a monthly food box to assist with addressing their health care and SDOH needs.

UniCare

- Funded community grants to organizations promoting food security and targeting education and employment development opportunities focused on high-risk youth.
- UniCare's population health teams conducted community health and wellness events, such as lead screenings and vaccinations.
- Helped to create and support hygiene closets in Kanawha, Grant, Marion, and Ohio counties.

Early and Periodic Screening, Diagnostic, and Treatment Benefit

MHT Performance Oversight

The MCOs are charged with ensuring MHT member access to critical and comprehensive healthcare services. Over the past SFY, BMS worked with the MCOs 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: [11]

- **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.

[11] 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.[12]

Table 1 compares the MHT program's screening and participation ratio metrics to the national average. BMS and the MCOs actively monitor program activities and performance metrics to create strategies and initiatives to promote the EPSDT benefit and improve health outcomes.

Table 1: MHT EPSDT Metrics[13]

Metric	MCO*	National Average**
Screening Ratio	Aetna: 66% THP: 64% UniCare: 54% WV Average: 61.33%	69%
Participation Ratio	Aetna: 55% THP: 53% UniCare: 51% WV Average: 53%	54%

As shown in *Table 1*, the MHT program is under performing compared to the national average for screening and participation ratios. However, the MCOs have 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.
- Underutilization of school-based health clinics.
- Lack of integration between well and sick visits.
- Increase in no-shows for well-care visits.
- School requirements for sports physicals instead of yearly physicals.
- Gap in education for parents and adolescents about the importance of well-care visits.

[12] MCO-reported data.
[13] Table legend:
*Data is MSLC/BMS calculated by MCO reporting for FFY 2023 (October 1, 2022 through September 30, 2023).
**Data is CMS calculated by MCO reporting for FFY 2021 (October 1, 2020 through September 30, 2022).

Despite the above challenges, the MHT 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 the MCOs to validate reporting and provide additional data points in EPSDT calculations. In early 2024, BMS implemented new quarterly reporting requirements to enhance ESPDT metrics.

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.

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 managed care 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.

Want to Know More?

Click here to view the 2023 Annual Technical Report.

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 managed care 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 MHT program continues to make progress in improving the quality of, and access to, healthcare services for its Medicaid members. The MCOs were largely compliant with federal and state managed care requirements.

Qlarant also noted all MCOs demonstrated their 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.

For the MHT program, Qlarant observed that the MCOs were methodical in their approach to reach their Performance Improvement Project (PIP) and Quality Improvement goals. The MCOs continue to make strides in enhancing the quality and accessibility of healthcare services for their beneficiaries. These positive developments are expected to lead to better health outcomes for the populations served. Qlarant determined that West Virginia's MCOs performed favorably in comparison to national average benchmarks in 72% of Healthcare Effectiveness Data and Information Set (HEDIS) measures and 74% of Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures.

MCO Profiles

Accreditation

Health plans 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. An MCO's overall rating is the weighted average of the MCO's HEDIS and 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 additional programs through NCQA, including but not limited to the electronic clinical data and health equity accreditation. The additional programs 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 2* for MCO accreditation, ratings, and additional programs.

Table 2: MCO Accreditation[14]

MCO	NCQA Accredited	Overall Rating	Additional Program
ABHWV	Yes	4	Electronic Clinical Data* & Health Equity Accreditation**
UniCare	Yes	3.5	Health Equity Accreditation** & Health Equity Accreditation Plus***
THP	Yes	3.5	N/A

Health Outcomes

HEDIS Measures

HEDIS 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. HEDIS measures focus on specific clinical areas and healthcare processes, providing insight into various health plan areas like preventive care, chronic disease management, behavioral health care, utilization management, and member satisfaction.

Want to Know More?

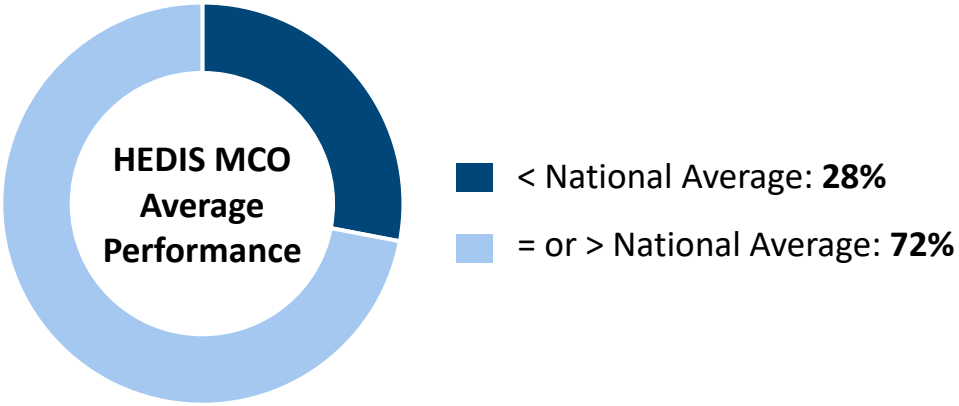
Visit here to view HEDIS Measures from the EQRO report.

Qlarant conducted EQR activities in West Virginia throughout 2023 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.

West Virginia's weighted averages were compared to the NCQA Quality Compass Medicaid MCO benchmarks. The MCOs, based on weighted averages, performed better than the national average benchmark for 72% of HEDIS measures reported in Appendix 1 of the EQRO report (*Figure 10*).

[14] Table legend:
*Health Equity Accreditation distinction recognizes organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.
**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.
***Health Equity Accreditation Plus distinction recognizes organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.

Figure 10: West Virginia HEDIS Compared to the NCQA Quality Compass Medicaid MCO Benchmarks



Appendix 1 of the EQRO report utilizes a diamond rating system to compare West Virginia HEDIS measure results to the NCQA Quality Compass Medicaid MCO benchmarks. Of the 218 measures that were compared, 158 received a diamond rating of two or higher, indicating that the MCO rates are equal to or exceed the NCQA Quality Compass National Average. Despite these positive results, there are opportunities for improvement: 60 measures fell below the national average, highlighting areas where each MCO can enhance improvement. BMS will continue to monitor and assess priority areas, incorporating Qlarant's recommendations to support the Managed Care Quality Strategy goals and objectives. This ongoing effort aims to improve the quality, timeliness, and accessibility of healthcare services for West Virginia's managed care beneficiaries. *Table 3* displays the number of measures, by diamond rating, that equal or exceed the NCQA Quality Compass National Average.

Table 3: MHT Performance Measures[15]

Performance Measures	MY 2022 (ATR 2023)	Comparison to National Benchmark
(ADV) Annual Dental Visit (2-3 Yrs)^	38.23%	♦♦
(PDENT) Percentage of Eligibles Who Received Preventive Dental Services^	47.1%	NC
(FUM) Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-Up (Total)^	54.25%	♦

[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 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.

Performance Measures	MY 2022 (ATR 2023)	Comparison to National Benchmark
(IMA) Immunizations for Adolescents – Combination 2^^	25.16%	♦
(IMA) Immunizations for Adolescents – HPV^^	26.33%	♦
(WCV) Child and Adolescent Well-Care Visits (Total)^^	50.34%	♦♦
(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)^^	86.34%	♦♦♦
(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)^^	71.08%	♦♦
(WCV) Child and Adolescent Well-Care Visits (12-17 Yrs)^^	49.70%	♦
(WCV) Child and Adolescent Well-Care Visits (18-21 Yrs)^^	23.58%	♦

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.

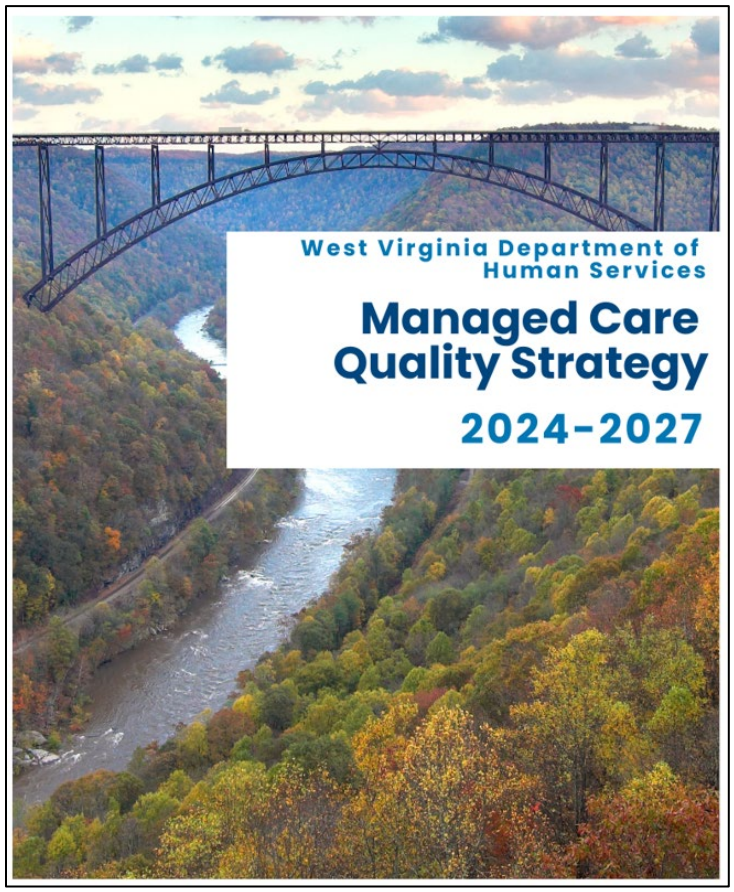
The DoHS website hosts many archived reports for public review. These reports provide historical insight into different components of the managed care program. Visit the DoHS site to view monthly enrollment figures, quality reports, legislative reports, and past annual reports.

The Managed Care Report to the Legislative Oversight Commission on Health and Human Resources Accountability is required by West Virginia Code Section 9-5-22 and is designed to provide legislators with information regarding multiple aspects of the MHT program. In addition to overall quality assurance insights, this report provides a more holistic view of West Virginia's Medicaid program.

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.



BMS's mission centers on a commitment to provide quality health care services for all West Virginia Medicaid and 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 Bureau for Social Services),

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

Figure 11: 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 AHPS, 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.

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.[16]

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

Access to high-quality healthcare is an essential element in fostering healthy and prosperous communities and families.[17] 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.

MHT Program Goals

BMS has established clear goals and objectives for the managed care 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 instance of substance use disorders (SUD),[18] high prevalence of chronic conditions,[19] and poor ranking in lifestyle habits and health outlook. In addition to these national trends, West Virginia faces other obstacles unique to the Mountain State. According to a 2023 Centers for Disease Control and Prevention report of resident deaths, West Virginia had the third highest age-adjusted mortality rate per 100,000 people for all causes. West Virginia also had the highest age-adjusted mortality rates for all accidental deaths, diabetes, and drug overdose deaths. 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: children, the elderly, and the under-employed. The five goals identified in the Managed Care Quality Strategy address these health challenges and will improve quality and health outcomes across the care continuum. In SFY24, BMS amended the MHT program goals to align with the State's 2024-2027 Medicaid Managed Care Quality Strategy (*Figure 11*).

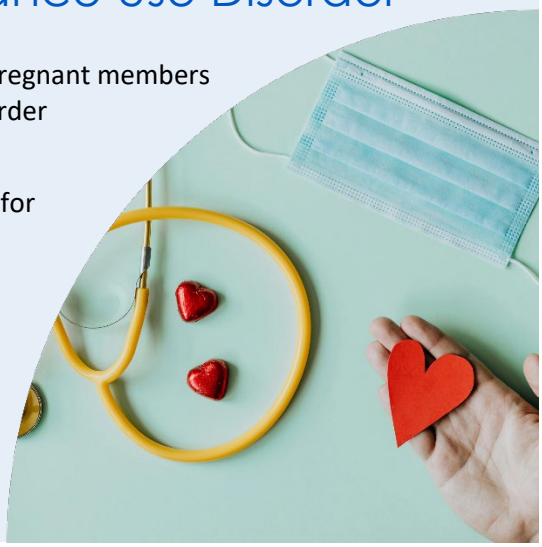
Addressing SUD

BMS continues to prioritize efforts to address SUD prevention and treatment and will work collaboratively with the MCOs to collect data and track performance on measures to assess the impact of the SUD-related programs and interventions. BMS has prioritized measures aimed at treatment and recovery efforts to align with BMS priorities around the SUD efforts, such as emphasizing prevention, community engagement, support, and research as integral components of the State's approach to addressing SUD.

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

Measure of Success: Substance Use Disorder

- ABHWV entered into a pilot study to assist pregnant members who are also living with SUD/opioid use disorder diagnoses.
- UniCare conducted vaping education events for youth.
- THP initiated the training of THP staff to be Narcan administrators and trainers to help address the SUD crisis.



Quality Withhold Program

In SFY24, Senate Bill 820 charged DoHS, BMS with developing and implementing a managed care quality withhold program based upon nationally-recognized measures of performance outcomes including those related to SUD inpatient care. The capitation withhold program will begin on July 1, 2025. The program retains 1% of aggregate MCO capitation payments. BMS has aligned the quality withhold measures with performance measures selected for the 2024-2027 Managed Care Quality Strategy. Additional program details, specific measure, weights, and targets for the program will be provided in the SFY25 annual report.

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 MCOs to enhance Medicaid program integrity. The 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 4*). Metrics include the number of new audits initiated, number of fraud referrals, and total overpayment recoveries.[20]

Table 4: Program Integrity Metrics

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

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

West Virginia SFY22[21]	
	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 5*). 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

[20] 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.
[21] SFY22 data is reported based on the SFY22 annual report and, due to change in reporting platforms, cannot be verified independently.

enforcement investigations while maximizing the ability of participating managed care plans to oversee the quality and appropriateness of Medicaid payments. We believe this increase has, and will continue to have, a significant impact on provider billing compliance and enhance the overall integrity of the Medicaid program.

Table 5: SFY24 Prepayment Reviews

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

Additional Resources

Program Overview: How is Medicaid Funded?

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

Quality Assurance: External Quality Review

- 2023 Annual Technical Report
- NCQA Accreditation Process
- NCQA's Health Plan Report Card for West Virginia
- West Virginia DoHS Overview of all Medicaid Reports

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

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
www.aetnabetterhealth.com/westvirginia

UniCare Health Plan of West Virginia, Inc.
200 Association Drive, Suite 200
Charleston, WV 25311
www.unicare.com

The Health Plan, Inc.
1110 Main Street
Wheeling, WV 26003
www.healthplan.org

Highmark Health Options of West Virginia, Inc.
614 Market St.
Parkersburg, WV 26101
https://wv.highmarkhealthoptions.com

Appendix

Acronyms List

Acronym	Definition
ABHWV	Aetna Better Health of West Virginia
ATR	Annual Technical Report
BMS	Bureau for Medical Services
BSS	Bureau for Social Services
CDC	Center for Disease Control and Prevention
CMS	The Centers for Medicare & Medicaid Services
CY	Calendar Year
DoHS	Department of Human Services
DPP	Directed Payment Program
EQR/EQRO	External Quality Review/ External Quality Review Organization
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
HEDIS	Healthcare Effectiveness Data and Information Set
HHOWV	Highmark Health Options West Virginia
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
PEIA	Public Employees Insurance Agency
PHE	Public Health Emergency
PIP	Performance Improvement Plan
SDOH	Social Determinants of Health
SFY	State Fiscal Year
SSA	Social Security Act
SSI	Supplemental Security Income

Acronym	Definition
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
THP	The Health Plan
WVCHIP	West Virginia Children's Health Insurance Program