Mountain Health Promise:
Reporting Required by W. Va. Code §9-5-27

July 2022

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

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Executive Summary

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) administers Mountain Health Promise (MHP), West Virginia's specialized managed care program for children and youth in foster care or the adoption assistance program. MHP is a full-risk managed care program that provides physical, dental, behavioral health, and socially necessary services for approximately 28,000 children and youth across the State.[1] Per W. Va. Code §9-5-27, MHP seeks to:

- Reduce fragmentation and offer a seamless approach to participants' needs;
- Deliver needed supports and services in the most integrated and cost-effective way possible;
- Provide a continuum of acute care services; and
- Implement a comprehensive quality approach across the continuum of care services.

In calendar year (CY) 2020, BMS contracted with one managed care organization (MCO), Aetna Better Health of West Virginia (ABHWV), which serves as the sole contractor for MHP and is responsible for coordinating care and benefits for MHP eligible children and youth. Additional support is provided to the MHP population through coordination with DHHR's Bureau of Social Services (BSS) and the Foster Care Ombudsman.

This report is required by W. Va. Code §9-5-27 and aims to present key program metrics and evaluate the transition to managed care. BMS filed an initial report with the Legislative Oversight Commission on Health and Human Resources Accountability and the Foster Care Ombudsman in July 2021. This is the second report of three, with the final report due by July 1, 2023.

Key Program Metrics

This report includes the following data metrics for March 1, 2021 to February 28, 2022:

- Number of MHP claims submitted, approved, denied, and appealed
- Resolution of appealed claims
- Average time of an appeal
- Average length of stay in a child residential care center
- Health outcomes[2]

Evaluation of Program Transition to Managed Care

DHHR contracted with West Virginia University (WVU) Office of Health Affairs to conduct an independent assessment of the MHP managed care program. This assessment found that "due to the short timeframe since implementation, which coincided with the start of the COVID-19 public health emergency, only limited data were available at the time the assessment was conducted." However, based on available data, WVU Office of Health Affairs concluded "MHP has established program processes and policies that do not impede, and in some cases, improve members' access to care. Additionally, the information available at the time of the independent assessment

[1] Represents average monthly enrollment for March 2021 through February 2022. Source: West Virginia Medicaid Managed Care and Fee for Service Monthly Reports

[2] At the time of this report, a full year of all validated MHP health outcomes data was not available since the program started in March 2020; however, this information will be included in an updated report by July 1, 2023.

indicates that the quality of care that members receive exceed Centers for Medicare & Medicaid Services (CMS) requirements in some conditions. The program is also on track to be cost effective, which will be clearer by the next independent assessment performed during the second waiver period."[3]

Mountain Health Promise Claims

Between March 1, 2021 and February 28, 2022, ABHCWV received 548,991 MHP claims. Table 1 below illustrates the total number of claims submitted, total number of claims approved or paid, and total number of claims denied for the period. The number of claims submitted reflects adjusted claims and excludes voided or reversed transactions. The number of claims denied includes determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

Table 1. Total Number of Claims Submitted, Approved, and Denied by Month for March 2021 through February 2022*

	Number of Claims Submitted[4]	Number of Claims Approved/Paid[5]	Number of Claims Denied[5]
March 2021	43,124	41,777	4,535
April 2021	47,124	36,981	2,655
May 2021	40,791	41,069	2,950
June 2021	47,968	50,698	2,951
July 2021	44,746	31,777	3,523
August 2021	39,252	45,397	3,971
September 2021	44,982	39,623	3,152
October 2021	48,880	44,826	3,665
November 2021	44,474	48,969	4,267
December 2021	52,066	48,526	3,746
January 2022	42,165	34,453	4,579
February 2022	53,419	49,799	3,279
Total	548,991	513,895	43,273

*Claims data reported by ABHWV as of June 15, 2022.

Appealed Claims

The Code of Federal Regulations (42 CFR §438.402) explains that members may file a request for an appeal following the receipt of a notification of an adverse benefit determination made by an MCO. Individuals making decisions on the appeal must have the appropriate clinical expertise and must not have been involved in any previous level of review or decision-making, nor be a subordinate of any such individual. Per WV BMS contract requirements, the MCO must also

[3] West Virginia University Office of Health Affairs (2021). *Independent Assessment of WV's 1915(b) Waiver for the Specialized Managed Care Plan for Children and Youth*.

[4] Figures include adjusted claims and exclude reversed or voided claims.

[5] Figures represent all claims paid or denied in the month, regardless of the month the claims were submitted.

provide notice of the appeal resolution and address at least 98% of appeals within 30 calendar days of the date the appeal is filed.

Table 2 below shows the number of MHP claims appealed, percentage of appeal resolutions wholly in favor of the member, and the appeal turnaround time or the average length of time from "Appeal Date of Receipt" to "Date of Resolution Letter" in days for the reporting period. During the reporting period a total of 16 claims were appealed of which two (12.5%) were resolved in favor of the members. The average appeal turnaround time in days for the reporting period was 10 calendar days.

Table 2. Total Number of Claims Appealed, Percentage of Appeal Resolutions Wholly in Favor of the Member, and Appeal Turnaround Time by Month for March 2021 through February 2022*

	Number of Claims Appealed	Percentage of Appeal Resolutions Wholly in Favor of the Member	Appeal Turnaround Time (in calendar days)
March 2021	0	0%	0
April 2021	5	20%	8
May 2021	1	0%	1
June 2021	1	0%	0
July 2021	2	0%	14
August 2021	1	100%	21
September 2021	2	0%	13
October 2021	1	0%	1
November 2021	0	0%	0
December 2021	0	0%	0
January 2022	1	0%	21
February 2022	2	0%	2

*Claims data reported by ABHWV as of June 15, 2022.

Children's Residential Care

Residential care centers are a type of live-in, out-of-home care placement for children and youth whose specific needs are best addressed in a highly structured environment with trained staff. These placements are time-limited and offer a higher level of structure and supervision than what can be provided in the home setting.

One programmatic goal of the MHP program is to prioritize in-state placements for child residential care services; therefore, Table 3 details the average length of stay (ALOS) in days for MHP members in in-state and out-of-state residential care centers and group homes by month. Monthly ALOS is calculated as the total length of stay in days for all members discharged during the month divided by the total number of members discharged for the month. The out-of-state data reported by ABHWV was collected from reports used by case management and utilization management within their organization. If members were reported on multiple reports, data that was the most complete and that showed the longest LOS (earliest admission dates and latest discharge dates) for those members was used.

Table 3. Average Length of Stay in Child Residential Centers by Month for March 2021 through February 2022*

	In-State Facilities		Out-of-State Facilities	
	ALOS in Residential Care Centers	ALOS in Group Homes	ALOS in Residential Care Centers	ALOS in Group Homes
March 2021	196	127	291	302
April 2021	176	111	374	356
May 2021	166	124	260	276
June 2021	161	152	259	321
July 2021	93	147	308	300
August 2021	145	141	286	350
September 2021	223	144	253	293
October 2021	176	160	226	250
November 2021	126	120	208	143
December 2021	164	133	269	282
January 2022	91	149	261	324
February 2022	220	147	315	307

*Child Residential Care data reported by ABHWV as of June 15, 2022.

Health Outcomes

Below are the most current External Quality Review Organization (EQRO)-assessed MHP health outcomes from the WV MHT & MHP 2021 EQRO Annual Technical Report published in April 2022.

BMS will continue to monitor MHP performance to understand the quality of care currently being delivered to members and to evaluate MCO performance over time. Per the statute, BMS will submit an updated and final version of this report to the West Virginia Legislative Oversight Commission on Health and Human Resources Accountability and the Foster Care Ombudsman by July 1, 2023.

WV HEDIS Measures

ABHWV's Healthcare Effectiveness Data and Information Set (HEDIS) measure rates reflect the ABHWV combined performance for MHT and MHP. Please use the following link to view HEDIS results for select 2021 (Measurement Year January through December 2020).

The final updated version of this report will include MHP-specific performance for the HEDIS measures.

WV Performance Measures

Table 4 below highlights MHP-specific performance measures available for Measurement Year (MY) 2020 covering March 2020 through December 2020. Due to the MHP program

implementation date of March 1, 2020, the number of performance measures available were limited.

Table 4. WV Performance Measures for Measurement Year (MY) 2020 (March 2020 through December 2020)

Performance Measure	Data Collection Method*	Eligible Population	Numerator	MHP ABHWV MY 2020 Rate	Comparison to Benchmarks**
Ambulatory Care: Emergency Department Visits – 0-19 Years (Visits per 1,000 Member Months) *Lower rate is better*	Administrative	192,509 Member Months	4,643 Visits	24.12	◆◆◆
Contraceptive Care-Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 3 Days	Administrative	37	2	5.41%	◆◆◆
Contraceptive Care-Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 60 Days	Administrative	37	5	13.51%	◆
Contraceptive Care-Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 3 Days	Administrative	37	2	5.41%	◆
Contraceptive Care-Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 60 Days	Administrative	37	15	40.54%	◆
Dental Sealants for 6-9 Year Old Children at Elevated Risk	Administrative	1,118	265	23.70%	◆
Follow-Up After Hospitalization for Mental Illness: 7 Days Follow-Up - Ages 6-7	Administrative	288	165	57.29%	◆◆◆
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up - Ages 6-7	Administrative	288	216	75.00%	◆◆
Percentage of Eligible (Children) that Received Preventive Dental Services	Administrative	20,061	10,085	50.27%	◆◆◆
Prenatal and Postpartum Care: Timeliness of Prenatal Care***	Hybrid	22	19	86.36%	◆◆
Diamond Rating System:					
MCO result is below the NCQA Quality Compass National Average.					◆

MCO result is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th percentile.	
MCO result is equal to or exceeds the NCQA Quality Compass 75th percentile.	
* Administrative data collection: rates are calculated using claims and other supplemental data. Hybrid data collection: rates are calculated using administrative and medical record data	
**Benchmark data source: Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set Chart Pack, November 2021	
***Caution should be used when interpreting rates based on small denominators. A denominator less than 30 is considered small.	

WV CAHPS Results

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey assesses healthcare quality by asking patients to report their experiences with care. The MHP CAHPS data is available for Children with Chronic Conditions (CCC). The data presented in Table 5 reflects survey measures and results for CY 2020. The table compares the ABHWV MHP results to the NCQA Quality Compass Medicaid HMO benchmarks.

Table 5. CY 2020 CAHPS for Children with Chronic Conditions (CCC) Population survey results

Child CAHPS Survey Measures	MHP ABHWV	Comparison to Benchmarks
Child Survey – CCC Population: Family Centered Care – Getting Needed Information (Always + Usually)	93.72%	
Child Survey – CCC Population: Access to Prescription Medicines	92.55%	
Child Survey – CCC Population: Coordination of Care for Children with Chronic Conditions	81.16%	
Child Survey – CCC Population: Access to Specialized Services (Always + Usually)	83.20%	
Child Survey – CCC Population: Family Centered Care – Personal Doctor Who Knows Child	92.80%	
Diamond Rating System:		
MCO result is below the NCQA Quality Compass national Average.		
MCO result is equal to or exceeds the NCQA Quality Compass national Average, but does not meet the 75th percentile.		
MCO result is equal to or exceeds the NCQA Quality Compass 75th percentile.		

MHP Performance Improvement Projects

Table 6 below highlights the Performance Improvement Projects (PIPs) for MHP for two state-mandated PIPS and one selected by ABHWV. Due to the implementation of the MHP program in March 2020, the EQRO was unable to assess PIP performance. ABHWV's interventions and performance data will be assessed and reported on in the EQRO Annual Technical Report for 2022. The results of the EQRO PIP assessment will be included in the final version of this report to be submitted by July 1, 2023. Please use the following link to view additional information regarding MHP PIPs.

Table 6. MHP Performance Improvement Projects (PIPs)*

2021 PIPs	State Mandated	State Mandated	ABHWV Selected
Topic	Annual Dental Visits	Care for Adolescents	Reducing Out-of-State Placements for Children in Foster Care
Aim	Will implementation of collaborative member, provider, and managed care plan interventions improve Annual Dental Visit rates among children ages 2-3 and Preventative Dental Services rates among children 1-20 enrolled in the Mountain Health Promise program?	Will the implementation of member, provider, and managed care plan interventions increase the rates of adolescent care, including well visits and immunizations received amongst members ages 9-21 enrolled with Aetna Better Health of West Virginia Mountain Health Promise?	Will implementation of comprehensive and collaborative member, provider, and managed care plan interventions reduce out-of-state placements for children in foster care?
Performance Measure(s), Measure Steward, & Population	**PM 1:** Annual Dental Visits for 2-3 Year Olds **Measure Steward:** NCQA **Population:** Children 2-3 years of age **PM 2:** Percentage of Eligibles that Received Preventative Dental Services **Measure steward:** CMS **Population:** Children, adolescents, and adults 1-20 years of age	**PM 1:** Immunizations for Adolescents (Combination 2) **Measure Steward:** NCQA **Population:** Adolescents 13 years of age **PM 2 and 3:** Child and Adolescent Well-Care Visits: 12-17 Year Olds and 18-21 Year Olds **Measure Steward:** NCQA **Population:** Adolescents and adults 12-21 years of age	**PM 1:** Reducing Out-of-State Placements for Children in Foster Care **Measure Steward:** Homegrown measure **Population:** Child and adolescent members in foster care

**ABHWV PIP performance will be evaluated in the EQRO Annual Technical Report for 2022.*