MEDICAID 101

Specialized Managed Care for Children and Youth Waiver

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

Medicaid 101: West Virginia's Mountain Health Promise Program

Introduction

This manual provides a brief overview of the West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) implementation of the 1915(b) Specialized Managed Care for Children and Youth waiver, and the 1915(c) waiver for Children with Serious Emotional Disturbance Disorder (CSED). These two waivers currently function as the Mountain Health Promise (MHP) program. The MHP program intends to provide specialized managed care for children in foster care, children receiving adoption assistance, and children with serious emotional disorders along with other Socially Necessary Services (SNS) by ensuring voluntary enrollment into one managed care organization (MCO). Children enrolled under the 1915(b) waiver may opt-out of managed care in favor of fee for service enrollment, but the 1915(c) waiver for the CSED population does not provide this option. The information in this manual should not be considered official Medicaid policy. Rather, this manual is intended to serve as an accessible resource regarding the 1915(b) and 1915(c) waivers, collectively known as the MHP program. The authors of this document have taken every effort to list the sources referred to and used in its development. For questions related to the MHP program or any of the information presented in this document, please see the contact information in the appendix.

What are 1915(b) and 1915(c) Waivers?

In 2018, DHHR received approval from the Centers for Medicare and Medicaid Services (CMS) for the 5-year section 1115 demonstration titled "Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders" (Project Number 11-W-00307/3). Subsequently approved amendments to the 1115 waiver allowed the state to enroll the foster care and adoption assistance population along with the CSED waiver population into one MCO.

Section 1915(b) of the Social Security Act provides flexibility for the states to modify/adapt their care delivery systems. Since its enactment in 1981, Section 1915(b) enables CMS to provide freedom of choice for the states and waive statutory requirements. Two provisions under this law can be used by states to implement care delivery systems:

- Section 1915(b)(1) allows states to mandate enrollment in a managed care organization or a primary case management program.
- Section 1915(b)(4) allows states to limit the number of providers delivering specific Medicaid services.

Section 1915 (c) of the Social Security Act provides guidelines for states to develop home and community-based services to meet the needs of people in need of long-term care in their communities rather than in an institutional setting. Home and community-based services such as the Mountain Health Promise program of West Virginia (WV) must:

- Demonstrate that waiver services do not cost more than providing similar services in an institutional setting
- Ensure the protection of all individual's health and welfare
- Provide adequate and reasonable standards to meet the needs of the CSED population
- Ensure an individualized and person-centered plan of care

States can submit 1915(b) and 1915(c) waiver applications to CMS using an official online transmittal form. CMS is required to respond within 90 days of its receipt. The 1915(b) waivers are approved for two years and can be renewed for up to two years thereafter. CMS is authorized under part of an amendment under the Affordable Care Act (ACA, P.L. 111-148) to approve section 1915 (b) and (c) waivers for five years if states choose to enroll dually eligible beneficiaries into MCOs.

Further reading: 1915 (b) Waiver Basics, 1915 (c) Waiver Basics (https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html)

What does West Virginia's Mountain Health Promise Program look like?

West Virginia's 1915(b) waiver for Specialized Managed Care for Children and Youth was approved in February 2020 as the Mountain Health Promise (MHP) program and runs concurrently with the 1915(c) program, known as the Children with Serious Emotional Disorder waiver. Collectively, the Mountain Health Promise program provides specialized managed care for children and youth currently in foster care or receiving adoption assistance along with the CSED population and is provided under authority of Section 1902(a)(23) of the Social Security Act. This section of the Social Security Act provides that enrollees may not be denied freedom of choice of qualified providers when enrolled in an MCO, the waiver under the 1115 waiver, the 1915(b) waiver allowed the procurement of a single managed care provider for this population, functioning as the MHP program. The 1915(b) waiver provides for the mandatory enrollment of the CSED population into one MCO. Aetna Better Health of West Virginia has served the state since 1996 and has been approved as the sole managed care provider for the MHP program.

The MHP program was implemented in March 2020 and provides holistic healthcare services specific to foster care children and youth and those receiving adoption assistance under age 21. In addition, the MHP program provides managed care in the form of home- or community-based care options for children with serious mental disorders between the ages of 3 and 21 who would otherwise need institutionalized care. The MHP program delivers cost-effective, integrated services to these populations by offering a continuum of care with broad oversight by representatives from DHHR's Bureau for Medical Services, Bureau for Family Assistance, and Bureau for Social Services (BSS) to promote continuous improvement.

The MHP program is specific to the adoption assistance and foster care population, along with the CSED population in West Virginia. The CSED program does not limit the eligibility for children in foster care or those receiving adoption assistance. All other Medicaid eligible children age 19 years and under are enrolled in the Mountain Health Trust program.

Further reading: West Virginia 1115 Substance Use Disorder Waiver (https://dhhr.wv.gov/bms/Programs/WaiverPrograms/Pages/Substance-Use-Disorder-(SUD)-Waiver-.aspx), Aetna Better Health West Virginia Member Handbook (https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/west-virginia/pdf/abhwv_member_mountain_health_trust_handbook.pdf) and Mountain Health Promise (https://www.aetnabetterhealth.com/westvirginia/members/medicaid/mountain-health-promise)

Goals of WV's Mountain Health Promise Program

Waiver for Specialized Managed Care for Children and Youth

The overall goal of West Virginia's 1915(b) waiver is to create a continuum of care that will improve the child welfare system. The waiver's specific goals are to:

- Develop and use electronic health records and other information technology resources to coordinate data sharing for MHP program members across families and stakeholders/agencies
- Reduce fragmentation and offer a seamless approach to participants' needs
- Deliver needed support and services in the most integrated and cost-effective way possible
- Provide a continuum of acute care services
- Implement a comprehensive quality approach across the continuum of care services
- Keep the child in-state to receive services

- Enhance the quality of care
- Improve health and social outcomes for youth
- Reduce the number of foster care cases by increasing family-centered care

Further reading: Proposal for a Section 1915 (b) Capitated Waiver Program Renewal Submittal Mountain Health Promise (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/WV_Mountain-Health-Waiver_WV-06.pdf)

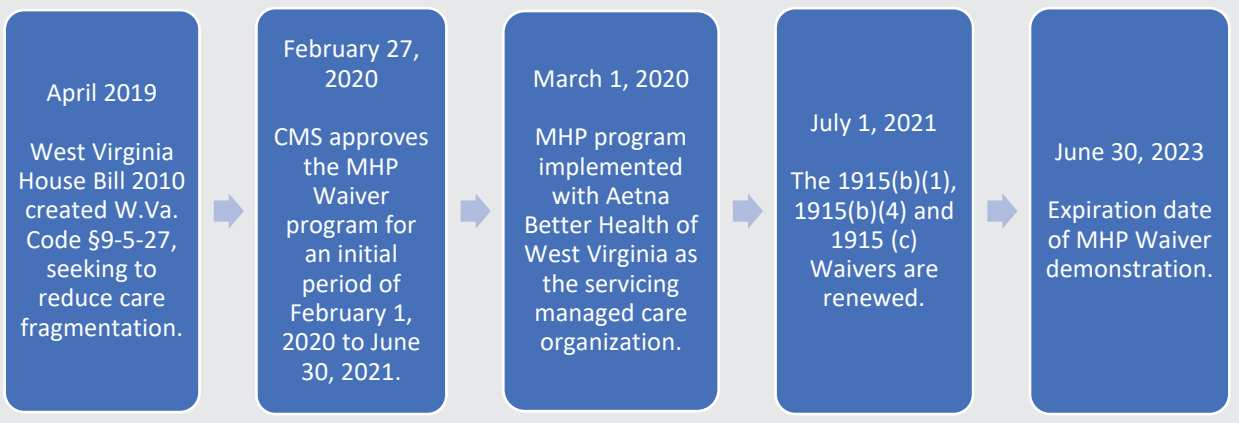
Waiver for Children with Serious Emotional Disorders

Like the 1915(b) waiver, the CSED waiver seeks to reduce fragmentation of care with the following overarching goals:

- Providing specialized, integrated, and enhanced care coordination for enrolled members
- Increasing the state's ability to implement and operationalize CSED services
- Reducing the burden of CSED providers by ensuring coordination with only one MCO
- Increasing cost-effectiveness and reducing service duplication with simplified utilization management, claims payments, member- and provider services

Further reading: State Waivers List: WV Children with Serious Emotional Disorder (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?f%5B0%5D=waiver_authority_facet%3A1571&f%5B1%5D=waiver_state_facet%3A731#content#content)

Timeline



Mountain Health Promise Waiver Services

Waiver for Specialized Managed Care for Children and Youth

Managed Care Organization Covered Medical Services

The MCO is responsible for the provision of medically or socially necessary services and is responsible for determining whether the following services are socially or medically necessary.

Ambulatory Surgical Center Services: Nursing, technicians, and related services; use of the facilities where surgical procedures are performed; drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; materials for anesthesia.

Cardiac Rehabilitation: Supervised exercise sessions with continuous electrocardiograph monitoring. The medically necessary frequency and duration of cardiac rehabilitation is determined by the enrollee's level of cardiac risk stratification.

Children's Residential Services: All services provided by a children's residential facility.

Chiropractor Services: Radiological examinations related to the service. Certain procedures may *have service limits.*

Clinic Services: Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a clinic (that is not part of a hospital) on an outpatient basis; general clinics, birthing centers, and health department clinics, including vaccinations for children.

Early and Periodic Screening and Treatment (EPSDT): Health care, treatment, and other measures to correct or ameliorate any medical or psychological conditions discovered during a screening. A service need not cure a condition to be covered under EPSDT. Services that maintain or improve a child's current health condition are also covered in EPSDT because they ameliorate a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent the development of additional health problems. Limited to individuals under age 21.

WHAT DOES MEDICALLY NECESSARY MEAN?

For Medicaid covered medical or other health services to children under age 21, it refers to services which: a) are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability; b) are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; c) are consistent with the diagnosis of the conditions; d) are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence; and e) will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

Emergency Shelter Services: Covers all emergency shelters and services offered.

Family Planning Services and Supplies: Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy.

Children with Special Health Care Needs Services: Provides linkage and coordination of services to all West Virginia children with special needs and limited direct medical services, equipment, and supplies to those families that meet financial and other program eligibility requirements. Services are provided to children under age 21 with the following diagnoses, but not limited to: cystic fibrosis, myelocystomeningocele/ myelodysplasia, congenital heart defects, craniofacial deformities, seizure disorders, and metabolic disorders.

Home Health Care Services: Nursing services, home health aide services, medical supplies suitable for use in the home. Residence does not include hospital nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or state institutions. Certain suppliers have service limits.

Hospice: In-home care provided to a terminally ill individual as an alternative to hospitalization. Nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide, and homemaker. Must have physician certification that enrollee has a life expectancy of *six (6)* months or less.

Hospital Services, Inpatient: Hospital services are provided for all enrollees on an inpatient basis under the direction of a physician. Excludes those adults in institutions for mental diseases. Excludes behavioral health inpatient stays with a DRG of 425-433 or 521-523 or MS-DRG 880-887 or 894-897. A table describing the Diagnosis Related Group (DRG) codes can be found in the appendix of this manual (Table 1).

Unlimited medically necessary days based on diagnosis-related groups. Transplant services must be in a facility approved as a transplant center by Medicare and prior authorized by Medicaid.

Hospital Services, Outpatient: Services covered include preventive, diagnostic, therapeutic, all emergency services, or rehabilitative medical services.

Laboratory and X-Ray Services: All laboratory and x-ray services are ordered and provided by or under the direction of a physician. Includes laboratory services related to the treatment of substance abuse.

Nurse Practitioner (NP) Services: Services provided by a nurse-midwife, nurse anesthetist, family, or pediatric nurse practitioner.

Other Services (Speech Therapy, Physical Therapy, or Occupational Therapy): Treatment or other measures provided by speech, physical or occupational therapists to correct or ameliorate any condition within the scope of their practice.

Physician Services: Includes medical or surgical services of a dentist, medical services related to the treatment of substance abuse, and fluoride varnish services. Physician services may be delivered using telehealth.

Podiatry Services: Treatment for acute conditions, i.e., infections, inflammations, ulcers, bursitis, etc. Surgeries for bunions, ingrown toenails. Reduction of fractures, dislocation, and treatment of sprains. Orthotics.

Private Duty Nursing: Nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by hospitals or skilled nursing facilities.

Prosthetic Devices and Durable Medical Equipment: Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. Medically necessary supplies, orthotics, prosthetics, and durable medical equipment.

Right from the Start Services (RFTS): Services aimed at early access to prenatal care, lower infant mortality, and improved pregnancy outcomes. Care coordination and enhanced prenatal care services. Pregnant women (including adolescent females) through sixty (60) day postpartum period and infants less than one (1) year of age. No prior authorizations can be required for RFTS services.

Rural Health Clinic Services, including Federally Qualified Health Centers: Physician, physician assistant, nurse practitioner, nurse-midwife services, supplies, and intermittent visiting nurse care in designated shortage areas.

Tobacco Cessation: Diagnostic, therapy, counseling services, and quit line services. The children's benefit also includes the provision of anticipatory guidance and risk-reduction counseling regarding tobacco use during routine well-child visits.

Transportation, Emergency: Transportation to secure medical care and treatment on a scheduled or emergency basis.

Vision Services: Services provided by optometrists, ophthalmologists, surgeons providing medical eye care, and opticians. Professional services, lenses including frames, and other vision aids. Vision therapy.

Covered Dental Services

Dental Services (Children): Services provided by a dentist, orthodontist, or oral surgeon or dental group to children under the age of 21. Includes emergency and non-emergency: surgical, diagnostic, preventive, and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures.

Covered Behavioral Services

Behavioral Health Rehabilitation for Individuals Under Age Twenty-One, Psychiatric Residential Treatment: Behavioral health rehabilitation occurring in a children's residential treatment facility. Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, mental disability, and substance use disorder.

Behavioral Health Outpatient Service: Behavioral health clinics, behavioral health rehabilitation, targeted case management, psychologists, and psychiatrists. (Emergency room services are included in the MCO benefits package.) Diagnosis, evaluation, therapies, including medication-assisted treatment, and other program services for individuals with mental illness, mental disability, and substance use disorder.

Psychological Services: Services provided by a licensed psychologist in the treatment of psychological conditions. Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.

Hospital Services, Inpatient – Behavioral Health and Substance Abuse Stays: Inpatient hospital services related to the diagnosis, evaluation, and treatment of behavioral health or substance use disorders.

Inpatient Psychiatric Services for Individuals Under Age Twenty-One: Active treatment of psychiatric condition through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the enrollee's condition or prevent regression so the service will no longer be needed.

Drug Screening: Screening ordered by the treating practitioner that is deemed medically necessary and reasonable within commonly accepted standards of practice. Results are intended to alter patient management decisions. The full scope of benefits is detailed in WV Provider Manual, Chapter 529. Standing orders must be individualized for each enrollee and updated every 30 calendar days; drug screenings in excess of 24 per calendar year are subject to prior authorization. All limitations are detailed in WV Medicaid Provider Manual, Chapter 529.2.

Substance Use Disorder (SUD) Services: Targeted case management and physician-supervised medication and counseling services provided to treat those with SUD. Comprehensive SUD state plan and waiver services listed in Article III, Section 11.10 Opioid Treatment Program services included in the SUD waiver will be provided through Medicaid Fee-For-Service (FFS).

Serious Emotional Disturbance Waiver Services: Provides children with some mental health conditions with special intensive support to help them remain in their homes and communities.

Further reading: Proposal for a Section 1915 (b) Capitated Waiver Program Renewal Submittal Mountain Health Promise (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/continuum-care/wv-creating-continuum-care-medicaid-enrollees-substance-demo-app-12062016.pdf) and *Aetna Better Health West Virginia Member Handbook (https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/west-virginia/pdf/abhwv_member_mountain_health_trust_handbook.pdf)*

Additional requirements/provisions for certain services for children in foster care or receiving adoption assistance

In addition to the covered services summarized above, the agreement between DHHR and Aetna Better Health of West Virginia requires that all children entering, or re-entering foster care undergo an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam within 30 days of placement. In West Virginia, the EPSDT exam is called “HealthCheck” and is coordinated between the Child Protective Services (CPS) worker and the MCO. For all other enrollees, it is the responsibility of the MCO to ensure initial screening of all healthcare needs within 90 days of enrollment. Related to the EPSDT exam and initial health screenings, the MCO is required to:

- Provide notification of screening due dates to the enrollee or his representative
- Perform the screenings according to the State-determined periodicity schedule
- Make the necessary referrals
- Track referrals and treatments
- Report the results via the encounter reporting system
- Report results as necessary to meet federal requirements, as requested by DHHR

Waiver for Children with Serious Emotional Disorders

In-Home Family Support: A family support worker, along with an in-home family support therapist works with the member and the family on the implementation of skills and interventions that will allow the family to function effectively.

Independent Living/Skills Building (Day Habilitation): These services focus on enabling the enrollee to attain or maintain his/her potential, through the provision of physical, occupational, or speech therapy, participation in scheduled activities and acquiring skills, positive social behavior, and interpersonal competence by utilizing a Therapeutic Mentoring model.

Job Development (Prevocational Services): The Child and Family Team (CFT) will determine a specific Plan of Care that will provide work and learning experiences, volunteering opportunities and the development of non-job specific strengths, and skills that will contribute toward employability in a community setting.

FEE-FOR-SERVICE AND MANAGED CARE

Fee-for-service (FFS): States directly pay providers a flat fee for each service provided. Managed care: States contract with health plans or MCOs and pay these groups a monthly per member capitation payment to provide all covered Medicaid services.

Respite Care, In-Home: Provision of temporary relief to the member's regular caregiver that includes all the necessary care usually afforded the member, in the member's home. Foster care children or children living in facilities do not qualify for this in-home service.

Supported Employment, Individual: Ongoing support services for adult members who need intensive support to obtain and maintain an individual job in the West Virginia workforce at or above minimum wage, utilizing CSED waiver non-medical transportation to and from the member's residence.

Wraparound Facilitation: Facilitator who engages the family and member in a partnership of shared decision-making regarding the Plan of Care by coordinating with supports, services, and resources for each member of the family.

Assistive Equipment: Items or a piece of equipment used to address the member's needs that arise because of his/her SED. This equipment should increase, maintain, or improve the member's functional capabilities.

Community Transition: Non-recurring set-up expenses up to $3,000 for adults transitioning from an institutional living arrangement to a private residential setting. Some allowable expenses are security deposits, essential household furniture, moving expenses, home adaptability expenses.

In-home Family Therapy: Counseling and training services for members and family provided by a licensed mental health professional, assisted by the in-home Family Support worker.

Mobile Response: Round-the-clock services are designed to respond immediately to issues that threaten the member's ability to function in the community, with services such as de-escalation, issue resolution support and the development of a stabilization plan. These services cannot duplicate other services received by the member.

Non-Medical Transportation: Foster parents are excluded from this service. This service offers transportation to members to and from local, public community locations for services specified in the plan, in support of the member's Plan of Care.

Peer Parent Support: Services designed to offer support to the parent/legal representative/foster parents of the member with SED, as mentors with lived experience. This support service is non-clinical in nature and does replace the in-home Family Support worker or Family Therapy.

Respite Care, Out-of-Home: These services are provided by a certified therapeutic foster parent in a certified therapeutic foster home but are only available to children currently living in their natural family home or in adoptive family homes. Children living in Therapeutic Foster homes are excluded from this service since the payment to foster families includes respite care.

Specialized Therapy: Activity therapy such as music, dance, art or play therapy related to the care and treatment needs arising from the member's SED. These are considered professional services, promoting the member's full participation in the community.

Additional provisions for certain services for children with serious emotional disorder

CMS awarded West Virginia grant funds to create comprehensive background checks for employees with direct patient care access. This program's purpose is to protect members from abuse, neglect, or financial exploitation. This program is administered by DHHR in consultation with the U.S. Department of Justice, WV State Police Criminal Investigation Bureau, the Federal Bureau of Investigation, and CMS as the WV Clearance for Access: Registry & Employment Screening.

Members of the CSED population may live with natural or adoptive families and receive services in their homes. Children living in Therapeutic Foster Homes licensed/certified by BSS who are in the custody of DHHR, receive their services in-home or in the community, and must be re-certified annually. During the initial enrollment process, the MCO will provide the member and family with a member handbook and a list of all approved CSED providers within a 25-mile radius of the member's residence.

The state has developed safeguards for the development of the Plan of Care (POC) to ensure that it is conducted in the best interest of the member. The MCO will review the POC and ensure that Direct Care Services remain separate and apart from wraparound facilitation services. No supervisory staff can be shared between these two agencies.

Further reading: Chapter 502 – Children with Serious Emotional Disorder Waiver (CSEDW) (https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20502%20CSEDW.pdf)

Mountain Health Promise provider network requirements

In accordance with DHHR Medicaid managed care network standards, it is the responsibility of the MCO to establish and maintain provider networks geographically accessible to the population served. The provider network must include credentialed primary care and specialist providers who are experienced or trained in trauma-informed approaches to care, and who have knowledge or experience in identifying child abuse or neglect. The MCO must have standards and policies in place to meet the requirements of 42 CFR §438.68, §438.206, and §438.207. This federal code requires that the MCO demonstrates the capacity to serve the expected enrollment in its service area in a timely and accessible manner. Other required availability and accessibility standards include:

- Ensuring that provider operating hours are no less than those offered commercial enrollees
- Services are provided in a culturally competent manner by providing reasonable accommodations to enrollees with limited English proficiency or disabilities
- Timely provision and access to care for emergency cases (immediate), urgent cases (within 48 hours), routine care (within 21 days), prenatal care (within 14 days), and initial appointment with primary care provider (within 45 days of enrollment)
- Selection of credentialled and qualified providers, complying with West Virginia C.S.R. §114-53-6 and 42 CFR 455, Subpart B and at a minimum
- Initial contract training of all providers within 30 days of contract execution followed by submission of provider training and education plans within 150 days of the operation start date

Further reading: § 438.207 Assurances of adequate capacity and services (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207), § 114-53-6. Credentialing & Recredentialing (https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/rule_053.pdf), and Disclosure of

Information by Providers and Fiscal Agents (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B?toc=1)

Who pays for the Mountain Health promise program in WV?

Section 1915(b) waivers services are paid by the enrolling managed care organization which receives monthly capitation payments from DHHR's Bureau for Medical Services (BMS). Payment to the MCO is based on enrollment data transmitted from DHHR's eligibility vendor (Optum) to the fiscal agent (Gainwell Technologies) for MCO-eligible members. In addition to submitting eligibility inconsistencies to the eligibility vendor and Fiscal Agent, inconsistencies in enrollment and payments must be submitted in writing to BMS within 45 days from the day the inconsistency was discovered, and BMS is required to supply requested information within 10 business days after receipt of the written notice. Payment adjustments will be included in the following month's capitation payment.

All CSED waiver services provided in the MHP program are administered through the state's 1915(b) waiver authority for specialized managed care and are integrated into the Per Member Per Month (PMPM) for enrolled members.

WHAT ARE CAPITATION PAYMENTS?

The American College of Physicians defines capitation payments as a payment system used by managed care organizations to control healthcare costs by paying a fixed amount of money per patient per unit of time for the delivery of healthcare services.

Mountain Health Promise program utilization

Data from an independent assessment completed in 2021 by West Virginia University's Office of Health Affairs (WVU OHA) identified a total of 20,143 members enrolled in the Mountain Health Promise (MHP) program as of November 30, 2020, under five categories. This number includes the 361 enrollees in the 1915(c) waiver program, a waiver that runs concurrently with the 1915(b) waiver providing care for children with serious emotional disorders.

Children receiving adoption assistance and children living with a legal guardian may opt-out of the MHP program in favor of the Medicaid fee-for-service program. Table 2 shows MHP eligibility categories and enrollment numbers. It is important to note that the categories listed in this table are not mutually exclusive.

Table 2: Mountain Health Promise Eligibility Categories and Enrollment Numbers from March to November 2020

Category	Description	Number Enrolled
Foster care children, IV-E	This category is for children who are receiving 24-hour substitute care away from their parents or guardians and for whom the Title IV-E agency (DHHR BSS) has placement and care responsibility. This includes placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes.	**5,911**
Foster care children, non-IV-E	This category is for children who receive the same services above but do not meet Title IV-E funding requirements.	**3,397**
Children receiving adoption assistance	This population receives cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of DHHR or a child-placing agency licensed by West Virginia. This includes IV-E/non-IV-E.	**11,220**
Legal guardian (kinship)	This is a legal relationship between a child and a caretaker (not the child's biological parent), which may be considered as a permanent placement option for the child. This arrangement legally transfers all the rights and responsibilities for a child from DHHR to the caretaker.	**1,490**
Children with serious emotional disorders	This population includes children between the ages of 3 to 21 who receive support services in their homes and communities to avoid institutionalization. This enrollment is not limited to the foster care and adoption assistance populations.	**361**
Total		**22,018**

Source: Independent Assessment of WV's 1915(b) Waiver for the Specialized Managed Care Plan for Children and Youth, April 30, 2021

Mountain Health Promise Enrollee Services

Provision of services to enrollees is the responsibility of the MHP program. Enrollee services include open enrollment regardless of pre-existing conditions, coverage of inpatient stays, coverage of newborns, assignment of a primary care provider, transferring enrollee information upon disenrollment, provision of an enrollee services department, provision of enrollee handbooks and member identification cards, provision of a provider directory, an accessible website, new enrollee education or orientation, health education, screenings, and preventive care and protection of enrollee rights such as privacy provision of a grievance or appeals process.

Reporting Requirements

As part of the MHP program's agreement with DHHR, it must demonstrate the ability to provide services effectively, efficiently, and economically. Demonstration of these abilities is required to be reported in the certified data form on a schedule outlined in Table 3 (Appendix).

Quality Assessment and Evaluating the Impact of the Mountain Health Promise Program

Quality Assessment and Performance Improvement (QAPI) remains the responsibility of the MCO, Aetna Better Health of West Virginia. The QAPI must be able to detect under- and over-utilization, assess the quality of care, and provide for Performance Improvement Projects (PIP) based on outcomes of the QAPI. At a minimum, QAPI strategies should include:

- Annual measurement of performance in specified areas (e.g., immunization rates) and achievement of performance targets
- Multi-year performance improvement projects addressing clinical and nonclinical areas
- An approach for addressing systematic problems and critical incidents
- The development and usage of a sufficient health information system
- Proper administration of quality assessment and performance improvement activities

The administration of the QAPI program should be consistent with requirements of 42 CFR §438.330, "Quality Assessment and Performance Improvement Program."

In addition to the QAPI required of the MCO, CMS mandates that all states receiving 1115 waivers work with an independent evaluator to conduct a robust assessment of the impact of the demonstration project. DHHR has partnered with a team of researchers from WVU OHA to formally evaluate the state's 1915(b) waiver in 2021.

The WVU evaluation team worked with DHHR to create an independent assessment of the 1915(b) waiver. Access to care, quality of care, and cost-effectiveness were evaluated, and a detailed report was shared with DHHR in April 2021.

Further reading: §438.330 Quality Assessment and Performance Improvement Program and SFY 2020 Model Purchase of Service Provider Agreement for Mountain Health Promise Between West Virginia Department of Health and Human Services, Bureau for Medical Services Bureau for Children and Families

List of Acronyms

ACA – Affordable Care Act

BMS – Bureau for Medical Services

BFA – Bureau for Family Assistance

BSS – Bureau for Social Services

CC – Complication or Comorbidity

CFT – Child and Family Team

CMS – Centers for Medicare and Medicaid Services

CPS – Child Protective Services

CSED – Children with Serious Emotional Disorders

CSEDW – Children with Serious Emotional Disorders Waiver

DHHR – West Virginia Department of Health and Human Resources

DRG – Diagnosis Related Group

EPSDT – Early and Periodic Screening and Treatment

FFS – Fee-For-Service

ICF/IID – Intermediate Care Facilities for Individuals with Intellectual Disabilities

MCC – Major Complication or Comorbidity

MCO – Managed Care Organization

MHP – Mountain Health Promise

NP – Nurse Practitioner

PIP – Performance Improvement Projects

PMPM – Per Member Per Month

POC – Plan of Care

QAPI – Quality Assessment and Performance Improvement

RFTS – Right from the Start Services

SNS – Socially Necessary Services

SUD – Substance Use Disorder

TM – Therapeutic Mentoring

WV – West Virginia

WV CHIP – West Virginia Children's Health Insurance Program

WVU OHA – West Virginia University Office of Health Affairs

List of References

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Appendix

Table 1: Diagnosis Related Group (DRG) codes

DRG Code	Description	Source
425	Other hepatobiliary or pancreas Operating Room procedures without Complication Comorbiidity (CC)/Major Complication Comorbidity (MCC) code 425	ICD-10-CM/PCS MS-DRG v38.0 Definitions Manual (cms.gov)
426	Depressive neurosis	CMS Manual System - Table 3 FY 2006 DRG's and Adjustment Factor (p. 5)
427	Neurosis, except depressive	
428	Disorders of personality & impulse control	
429	Organic disorders and mental disability	
430	Psychoses	
431	Childhood mental disorders	
432	Cirrhosis and alcoholic hepatitis with MCC	ICD-10-CM/PCS MS-DRG v38.0 Definitions Manual (cms.gov)
433	Cirrhosis and alcoholic hepatitis with CC	
521	Alcohol/Drug Abuse or Dependence with CC	CMS Manual System - Table 3 FY 2006 DRG's and Adjustment Factor (p. 5)
522	Alcohol/Drug Abuse or Dependence with Rehabilitation Therapy without CC	
523	Alcohol/Drug Abuse or Dependence without Rehabilitation Therapy without CC	
880	Acute adjustment reaction and psychosocial dysfunction	Mental Diseases & Disorders - DRG Code Range 876-887 (aapc.com)
881	Depressive neurosis	
882	Neurosis except depressive	
883	Disorders of personality and impulse control	
884	Organic disorders and intellectual disability	
885	Psychoses	
886	Behavioral and developmental disorders	
887	Other mental disorder diagnoses	
894	Alcohol, drug abuse or dependence, left AMA	Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders - DRG Code Range 894-897 (aapc.com)
895	Alcohol, drug abuse or dependence, with rehabilitation therapy	
896	Alcohol, drug abuse or dependence, without rehabilitation therapy	
897	Alcohol, drug abuse or dependence, without rehabilitation therapy, without MCC	

Table 3: Mountain Health Promise Reporting Schedule

Reporting Requirement	Time Frame	Due Date
Quarterly Reports		
Enrollment and Membership Report	Quarterly	Within 45 calendar days of the end of quarter (by the 15th day of the second month following the end of the reporting period)
Provider Network Status Report	Quarterly	
Medical Claims Processing	Quarterly	
Experience Summary	Quarterly	
Medical Grievance and Appeals Report	Quarterly	
SNS Grievance and Appeals Report	Quarterly	
Dental Grievance and Appeals Report	Quarterly	
Behavioral Health Grievance and Appeals Report	Quarterly	
Lag Tables	Quarterly	
Summary of Claims Paid Outside Encounter Data and Sub-Capitation Arrangements	Quarterly	
Experience Summary for Capitated Arrangements	Quarterly	
Enrollee and Provider Services	Quarterly	
Medicaid-Related Financial Reports (Statement of Revenue and Expenses)	Quarterly	
Out-of-Network Utilization Report-Physical Health	Quarterly	
Out-of-Network Utilization Report-Behavioral Health	Quarterly	
Enrollee and Provider Services	Quarterly	
Medicaid-Related Financial Reports (Statement of Revenue and Expenses)	Quarterly	
Out-of-Network Utilization Report-Physical	Quarterly	
Quality Reports		
Written Description of PIPs and Results	Annually	July 15
PIP Progress Report	Quarterly	Within 45 calendar days of end of quarter
HEDIS	Annually	On or before June 15 (audited)
QAPI Annual Evaluation Report Including Status and Results	Annually	On or before June 15
QAPI CAP	Other	Within 30 calendar days of identification of systematic problem

Reporting Requirement	Time Frame	Due Date
CAHPS Enrollee Survey Analysis, Action Plan and Evaluation	Quarterly and annually	An annual analysis is due on or before August 15. Quarterly updates are due within 45 calendar days of end of quarter (see MHT-15)
Accreditation Review Report	Other	Upon completion or change in status
Encounter Data	Monthly	Within 30 calendar days of end of month
Adult and Child Core Quality Measures	Annually	On or before September 1
Provider Reports		
Provider Network Data	Monthly	Electronic provider directories to be submitted to the Department monthly
Provider Network Adequacy	Quarterly, annually, and other	• Full network – Annually by October 31 • All Network changes by specialty – Quarterly, 45 days after end of the quarter • PCP changes – 14 days after the change • Hospital changes – immediately • Material changes of other providers affecting service delivery – 14 days after the change
Provider Satisfaction Survey	Quarterly	Within 45 calendar days of end of quarter (by the 15th day of the second month following the end of the reporting period)
Suspension and Adverse Enrollment Action Report (formerly the CAF Suspension and PDC reports)	Monthly	By the 15th of the following month
Financial Reporting		
Annual Financial Statements	Annually	On or before June 1
Offices of the Insurance Commissioner Reports – Quarterly and Annually	Quarterly and annually	Concurrent with DOI submission
Third Party Liability Cases Not Pursued	Monthly	The 15th of each month (to include all events from the prior month)
Provider-Preventable Conditions		To be determined
PCP Payment Methodology	Other	Upon request from DHHR
Directed Payments Report	Quarterly	The 15th of each month (to include all events from the prior month)
Provider Payment Suspensions Report	Monthly	
MLR Reports and Calculations	Annually	Eight months after the end of the SFY
Recovery of All Overpayments Report (included in the FWA Report)		By the 15th of the month

Reporting Requirement	Time Frame	Due Date
IMD Report	Monthly	Submit on the 15th and 30th of each month
Hysterectomies and Sterilizations X	Annually	Submit attestation by October 1
EPSDT Services and Reporting	Other	Submit attestation by October 1
Other State Required Reporting		
Business Continuity Plan	Other	Within 10 business days of DHHR written request
Disaster Recovery Plan	Other	Within 10 business days of DHHR written request
Information Security Plan	Other	Within 10 business days of DHHR written request
Children's PRTF Services Report	Monthly	The 15th of each month (to include all events from the prior month)
System Quality Assurance Plan	Other	Within 10 business days of DHHR written request
Sexually Transmitted Diseases	Annually	Submit attestation by October 1
Tuberculosis	Annually	Submit attestation by October 1
Communicable Diseases	Annually	Submit attestation by October 1
MCO Annual Report	Annually	On or before April 1
Organization Chart	Annually	On or before October 1
Marketing Plan	Annually	On or before October 1
Subcontractor Monitoring Plan	Other	Within 10 business days of BMS written request
Data Accuracy and Completeness Plan	Annually	On or before October 1
Activities Summary, Analyses and Results of Provider/Beneficiary Utilization to Detect FWA	Annually	On or before June 15
HB 4217 Report	Annually	On March 30 of each year
Alternative Payment Model Report	Annually	August 15
FWA Reporting	Monthly	By the 15th of the following month
Disclosure of Ownership Reporting	Annually and other	• Annually, on or before July 1; • Upon request, within 35 calendar days; or • Upon change in ownership, within 35 calendar days
FWA Internal Compliance Plan	Annually	On or before October 1
Parity in Mental Health and Substance Use Disorder (SUD) Benefits Compliance Plan	Annually	On or before June 30
Claims Aging Report	Monthly	By the 15th of the following month

Reporting Requirement	Time Frame	Due Date
SNS underserved areas of the State where they additional SNS providers are needed	Monthly	
SED Waiver Reporting, including but not limited to: authorization reporting; grievances, appeals, and denials reporting; member satisfaction reporting; staffing/training reports; service plan reporting; critical incident reporting; claims reporting.	Monthly, quarterly annually and other	As defined by the SED waiver program

For additional information about the West Virginia Medicaid program, please contact the Bureau for Medical Services at 304-558-1700.

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