



West Virginia Medicaid

Mountain Health Trust Annual Report

State Fiscal Year (SFY) 2022

(July 2021 – June 2022)



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1 Program Overview | Medicaid Basics

What is Medicaid?

Medicaid provides publically 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**. Created 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 community or in an institutional setting, such as a nursing home, 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. States also have the option to cover other groups of individuals who otherwise may not be eligible under the federal standards. **West Virginia chooses to provide Medicaid assistance to numerous individuals through optional, State-crafted "coverage groups."**

Who Pays for Medicaid?

Medicaid is 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 rate is based on a formula which considers the average per capita income for each state relative to the national income average.

States like West Virginia, with lower average incomes, receive larger reimbursement rates from the federal government to help with Medicaid program costs. **In federal fiscal year 2022, West Virginia's starting FMAP rate was 74.68%**. This means the federal government reimbursed West Virginia approximately \$0.75 of every eligible dollar spent on Medicaid. **During the COVID-19 Public Health Emergency (PHE), FMAP increased by 6.2%, resulting in an enhanced FMAP for West Virginia of 80.88%.**

Want to Learn More?

Visit Medicaid.gov at <http://tiny.cc/FMAP1>

Visit the Kaiser Family Foundation at <http://tiny.cc/FMAP2>

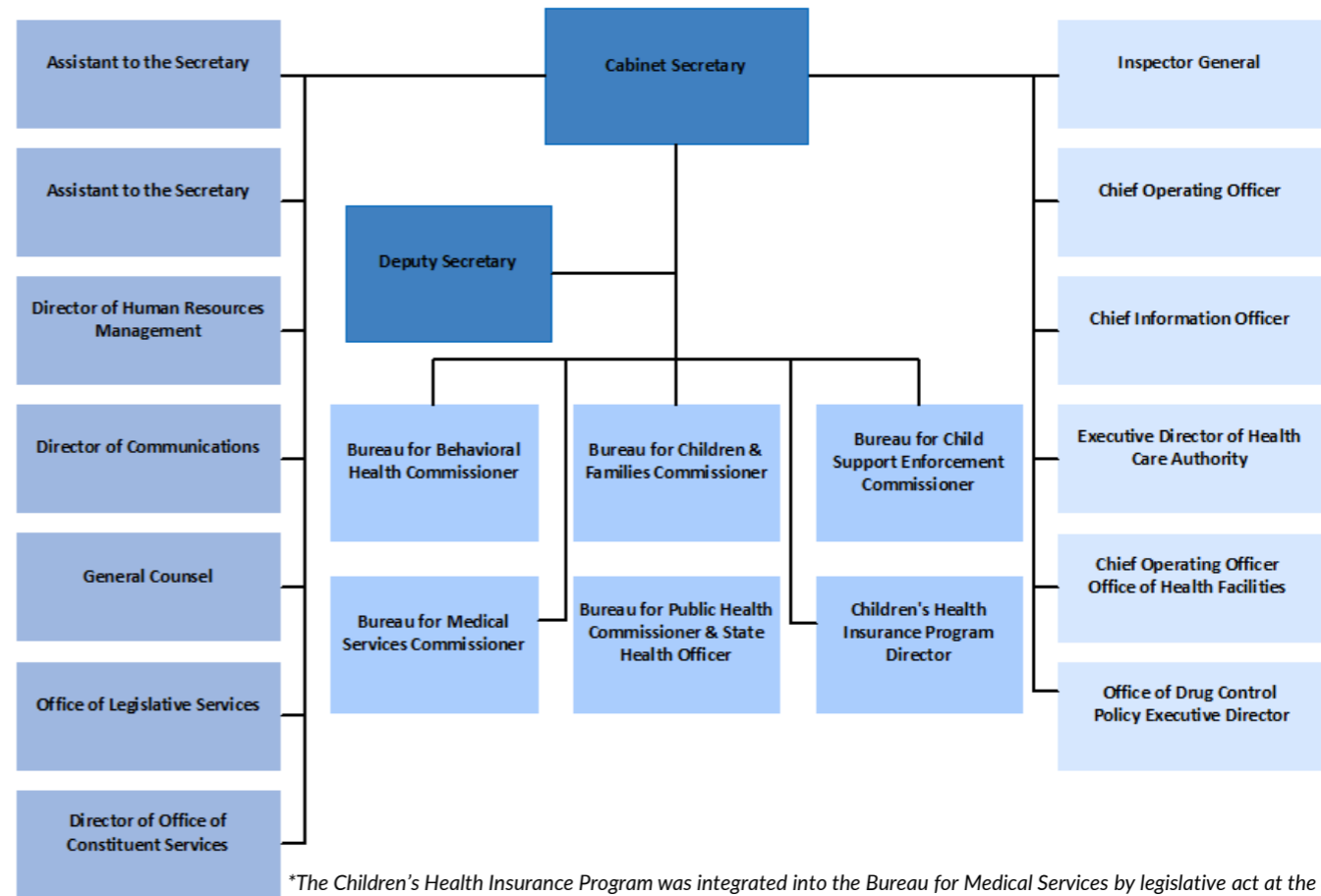
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Program Overview | West Virginia DHHR

The Department of Health and Human Resources (DHHR or Department) is the state’s organization responsible for supplying a wide range of necessary and life-saving services to West Virginia residents. Its mission is to promote and provide health and human services to the people of West Virginia in order to improve their quality of life. Department programs strive for effectiveness, efficiency, and accountability, as well as respect for the rights and dignity of the employees and public individual they serve.

DHHR’s purpose is to provide planning and coordination and to safeguard and oversee daily financial and administrative operations. The goal and objective of DHHR is to provide quality and cost-effective support for all Department programs and to supply accountability through accurate reporting of revenues and expenditures.

DHHR is comprised of five bureaus and the Office of the Inspector General. The five bureaus within the Department are the Bureau for Behavioral Health, the Bureau for Child Support Enforcement, the Bureau for Social Services, the Bureau for Medical Services (BMS), and the Bureau for Public Health. In total, the Department employs over 6,000 individuals statewide.



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Program Overview | West Virginia BMS

West Virginia 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; provides these services in a user-friendly manner to providers and members alike; and focuses on the future by providing preventative care programs.



How Does West Virginia Provide Medicaid?

BMS is the designated single state agency responsible for the administration of the state’s Medicaid program. BMS is responsible for providing access to appropriate health care for Medicaid-eligible West Virginians.

In 1996, the BMS Office of Medicaid Managed Care initiated a risk-based managed care program for certain groups of Medicaid recipients in West Virginia. Under this program, BMS contracts with managed care organizations (MCOs) for the provision of medically-necessary services provided by the State. While some services, like pharmacy, long-term care, and non-emergency transportation, are still provided on a fee-for-service basis, the managed care model serves the majority of West Virginia Medicaid recipients with a holistic approach to health care services.

Currently, BMS contracts with three MCOs through the Mountain Health Trust (MHT) program – Aetna Better Health of West Virginia (ABHWV), UniCare Health Plan of WV (UniCare), and The Health Plan (THP).

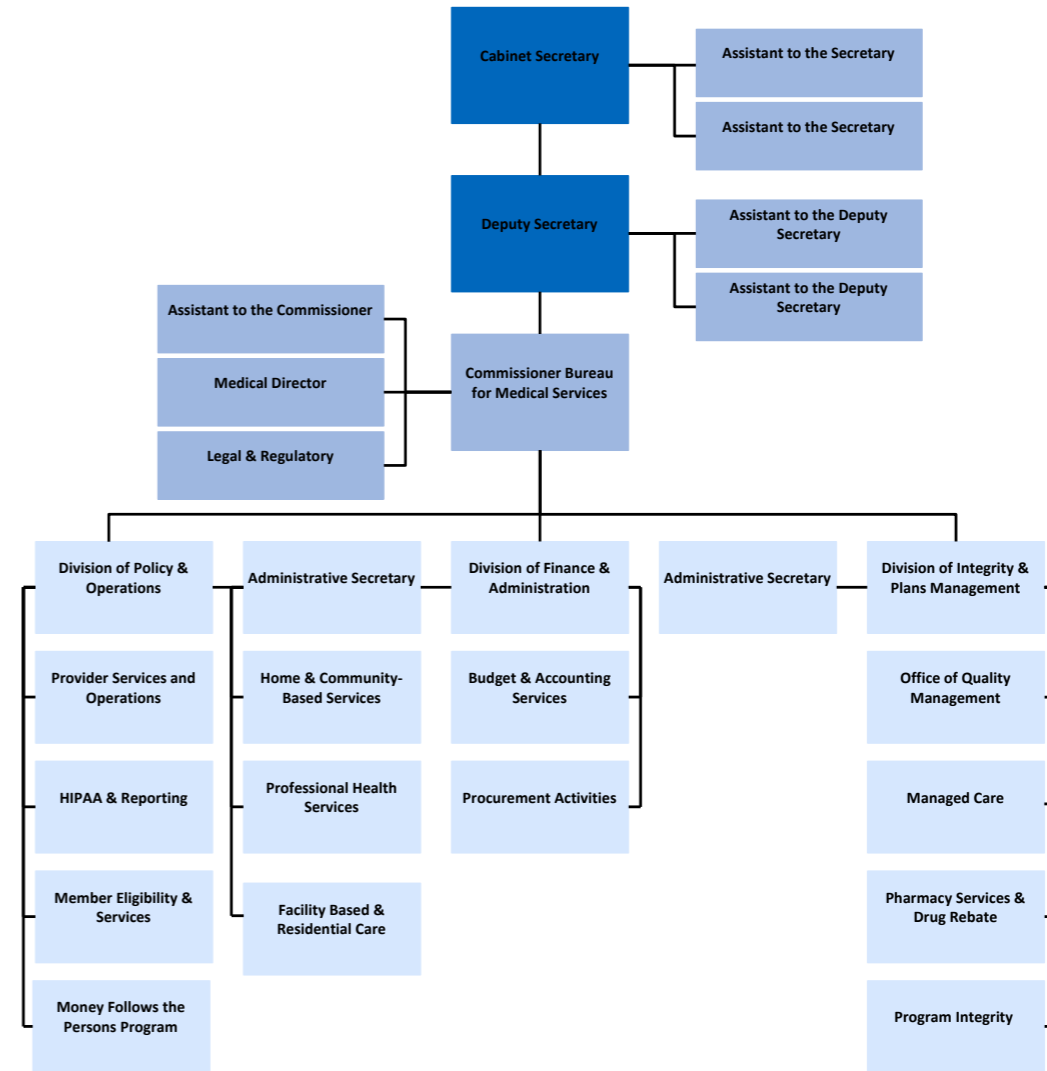
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Program Overview | West Virginia BMS

As the single state Medicaid agency, BMS is also responsible for establishing and administering the overall strategic direction and priorities for the West Virginia Medicaid program. This program provides essential health care coverage to children and adults with low income and people with disabilities.

MHT is overseen by the Office of Managed Care within BMS. Medicaid managed care members in the MHT program are currently enrolled with one of the state’s three MCOs: ABHWV, UniCare, and THP.

BMS has approximately 80 employees working closely with other bureaus to provide the best quality health care services to eligible adults, children, and pregnant women with low income residing in West Virginia. 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. These divisions include the Office of Legal and Regulatory Services, Division of Finance, Division of Plan Management and Integrity, and Division of Policy Coordination and Operations.



*The Children’s Health Insurance Program was integrated into the Bureau for Medical Services by legislative act at the end of SFY22

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Program Overview | MHT Statistics

Demographics

WV Population | 1.78 Million

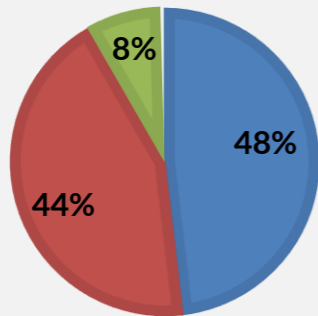
MHT-Medicaid Enrollment | 488,405



1 in 4 West Virginians are assisted by Medicaid through the MHT program.

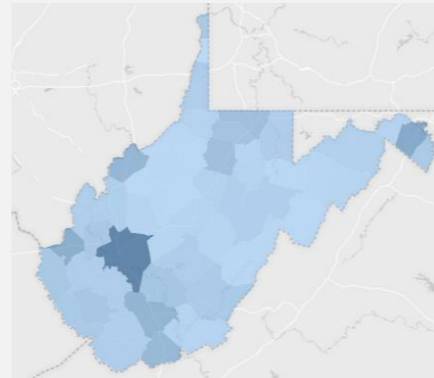
MHT-Medicaid Enrollment by Eligibility Category

- Temporary Assistance for Needy Families
- Adult Expansion
- Supplemental Security Income
- Children's Special Health Care Needs*
- Pregnant Women*



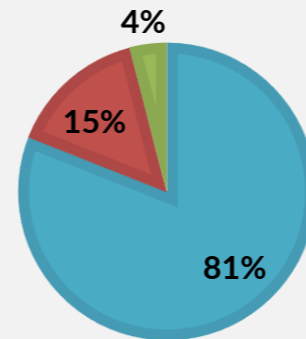
*Populations with <1% are not shown in the pie charts

MHT-Medicaid Enrollment by County



MHT-Medicaid Enrollment by Race

- Caucasian
- Other
- African American
- American Indian / Alaska Native*
- Asian*



Spending

\$1.90 Billion
Total MHT Expenditures in SFY 2022

MHT accounts for **36% of total SFY 2022 Medicaid Spending**

💰 86% federal dollars

💰 14% state dollars

Total Federal Spend

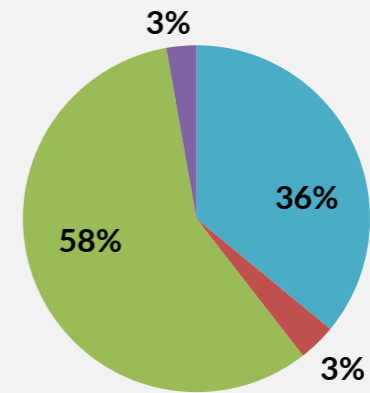
Total State Spend

\$1.63 Billion

\$270 million

\$5.28 Billion SFY 2022 Medicaid Total Dollars Spent

- MHT
- MHP
- FFS
- BMS Administration



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

Note: The metrics above reflect MHT eligibility via Medicaid only. West Virginia Children's Health Insurance Program (WVCHIP) is not included in this report. Data Sources: WV Census and MHT encounter data through June 30, 2022, as of September 2022.

New World, New Challenges, and New Solutions

The spread of the coronavirus disease 2019 (COVID-19) and emergence of COVID-19 variants in SFY21 had a global impact and challenged our country's health systems in ways unheard of in modern times. In response, BMS took emergency action to suspend Medicaid disenrollment and ensure eligible enrollees remained covered during the COVID-19 PHE.

Additionally, BMS worked with MCOs to reduce administrative burdens and provide flexible benefits. BMS took numerous emergency actions to assist providers and members including, but not limited to:

- Suspending prior authorization requirements for COVID-19 diagnostic testing.
- Suspending in-person and face-to-face meeting requirements for certain treatments and therapies.
- Authorizing and promoting the utilization of telehealth services among MCO network providers.
- Making vaccines available to all Medicaid members throughout West Virginia.

COVID-19 Cases

While progress has been made to combat the virus, as of July 1, 2022, **427,121 confirmed cases** and **7,176 deaths** from the virus have occurred in West Virginia since the beginning of the PHE.

COVID-19 Vaccines

As of July 1, 2022, over **2.8M doses** of the COVID-19 vaccines have been administered to West Virginians. **58.2% of West Virginians were reported to be fully vaccinated** (61.3% of children ages 5+, 65.5% of children ages 12+, 67.4% of adults 18+ and 85.5% of elderly 65+).

COVID-19 Resources

For Centers for Disease Control data on COVID-19 cases and vaccines, visit http://tiny.cc/CDC_COVID1.

For more information on current vaccines and COVID-19 best practices, visit the Centers for Disease Control at http://tiny.cc/CDC_COVID2.

For West Virginia DHHR data and resource on COVID-19, visit http://tiny.cc/WV_COVID.

COVID-19 and Continuous Enrollment

The COVID-19 outbreak and implementation of federal policies to address the PHE disrupted routine Medicaid eligibility and enrollment operations. In response to the COVID-19 PHE, the Families First Coronavirus Response Act allowed state Medicaid programs to qualify for a temporary 6.2% FMAP increase if certain requirements were met, including maintaining continuous coverage for individuals enrolled in Medicaid and CHIP as of, or after, March 18, 2020. Enrollment in Medicaid has grown significantly during the pandemic. Continuous enrollment has helped to preserve coverage and reduce Medicaid churn.

Once the PHE ends, continuous enrollment will cease, and states will have up to 14 months to complete all PHE eligibility redeterminations initiated during the 12-month unwinding period. In addition, the 6.2% enhanced FMAP will end. CMS has made it a top priority to ensure that when the PHE eventually ends and states resume routine operations, the transition process occurs in an orderly fashion that minimizes beneficiary burden and promotes continuity of coverage.

State Medicaid COVID-19 PHE Unwind Strategy

CMS released the COVID-19 PHE enrollment unwind guidance to states on March 3, 2022. This guidance gives states up to 14 months to complete all PHE eligibility redeterminations initiated during the 12-month unwinding period. It also provides guidance to state approaches for the unwind, including the approach to prioritizing members for the renewal process, and emphasizes continuity of coverage and the avoidance of inappropriate terminations.

PHE Unwind Resources

- For CMS State Health Official Guidance (SHO# 22-001), visit <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.
- For more information on actions other states are taking to prepare for the lifting of the continuous enrollment requirements, visit <https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey-executive-summary/?msclkid=9c3b6bc9cbd411eca36760ba7d9205cb>.
- For DHHR data and resource on COVID-19, visit http://tiny.cc/WV_COVID.

What Is a Medicaid 1915(b) Waiver?

Medicaid is governed at the federal level by Section 1900 of the Social Security Act (SSA). Section 1915(b) of the SSA provides states the flexibility to modify their Medicaid program's delivery system including the implementation of managed care. To implement an alternative delivery model, a state must submit a 1915(b) waiver application to CMS for approval.

What Is Included in the Medicaid 1915(b) Waiver?

The 1915(b) waiver application includes questions regarding the following topics:

- Delivery system model.
- Eligible populations.
- Access standards.
- Program operations (e.g., marketing, member rights, grievance system, etc.).
- Program monitoring and prior waiver period monitoring results.
- Program cost-effectiveness.

What 1915(b) Waiver Activities Have Occurred?

The MHT program has successfully operated in West Virginia for 12 waiver periods. Every two years, states are required to renew their 1915(b) waivers and report program monitoring results for the prior waiver period. In SFY 2022, BMS submitted the MHT 1915(b) waiver renewal. The current waiver renewal is for a 24-month period beginning July 1, 2021, and ending June 30, 2023.

The State continues to meet regularly with the Medical Services Fund Advisory Council, the MCOs, and contractors. These meetings provide the State with a high level of oversight of program administration issues and promotes continuous improvement in all aspects of the program (e.g., enrollment, health care delivery, external monitoring, etc.). BMS also works with representatives from other state agencies, as needed, to raise issues of concern to their constituencies and share information about the MHT program for their staffs and beneficiaries.

How Was the Public Involved in the 1915(b) Waiver Renewal?

As part of the 1915(b) waiver process, BMS published the Quality Strategy for public comment in March 2021. BMS reviewed all public comments and updated the Quality Strategy in April 2021 before submitting to CMS for approval.

What are Directed Payment Programs (DPP)?

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. 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 Quality Strategy goals. States must submit proposed DPPs to CMS before implementation. CMS reviews the proposals to ensure they are within federal guidelines, and if applicable, properly tied to advancing the State’s Quality Strategy goals.

In SFY2022, West Virginia’s health delivery system received approximately:

\$306.3M

through CMS approved
Hospital DPP

\$43.6M

through the SB546
(Provider Specialist) DPP

Additional Impact of Supplemental Payments

\$24.9 Million for School-Based Services

\$13.6 Million for Direct Medical Education

**\$1.8 Million for the Health Insurance
Premium Payment Program**

\$194 Thousand for Critical Access Hospital Settlements

(BMS distributes other supplemental
payments not included in this list)

3 Managed Care Program | Introduction

What is MHT?

MHT-Medicaid is West Virginia's Medicaid managed care program, administered by BMS. West Virginia Medicaid members may review the health plans and benefits offered by the contracted MCOs and choose the MCO that best meets their needs.

BMS currently contracts with three MCOs to provide services to West Virginia Medicaid beneficiaries. Those MCOs are:

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

Once enrolled, members are asked to choose a primary care provider (PCP) who serves as the member's medical home, their main source of care, and the facilitator of access to any specialty care.

While WVCHIP falls under the MHT umbrella, it is not summarized in this report.

MHT Program Goals

Improve access to high-quality health care.

Improve member satisfaction with the program.

Provide a medical home to every member.

Increase the use of primary and preventative care.

Improve birth outcomes.

Improve compliance with immunization schedules and well child visits.

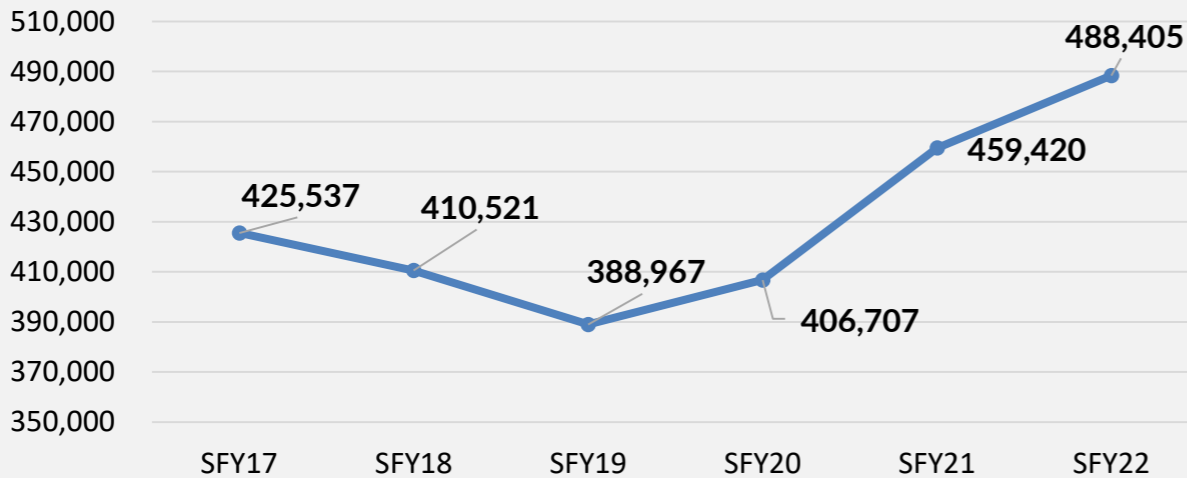
Contain the rising cost of Medicaid through appropriate use of services.

Improve population health through a person-centered system of care.

MHT-Medicaid Membership

The MHT-Medicaid program serves West Virginians who meet federal eligibility guidelines relating to individual or family income, assets, and health care needs. Covered members include children and their parents or other caretaker relatives, adult Medicaid expansion members, pregnant women, and qualifying individuals receiving SSI. At the end of SFY 2022 (June 30th), the total number of members enrolled was 488,405.

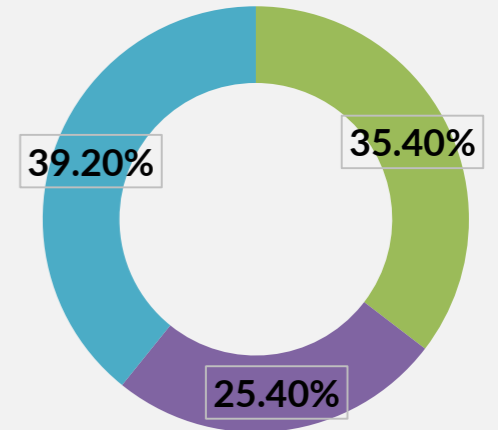
MHT-Medicaid Enrollment by Month



Data Source: MHT encounter data through June 30, 2022, as of September 2022.

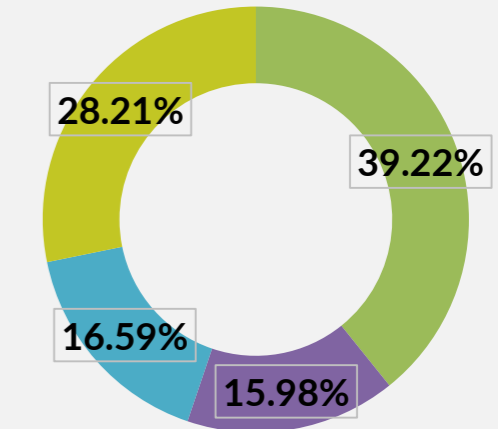
MHT-Medicaid Enrollment by MCO

- Aetna
- THP
- Unicare



MHT-Medicaid Enrollment by Age

- Less than 20
- 20 - 29
- 30 - 39
- Over 40



States are required to provide members certain "mandatory services" to qualify for federal matching funds. However, BMS has chosen to also provide "optional services" to increase the range of overall services offered to members.

The following list provides examples of both mandatory and optional Medicaid services that are covered by MCOs under the MHT-Medicaid program. (This list is not exhaustive and is subject to change. Always verify coverage with your MCO/Health Plan prior to service.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> ○ Ambulatory Surgical Center Services ○ Behavioral Health Outpatient Services ○ Behavioral Health Rehabilitation (Children under 21 years) ○ Psychiatric Residential Treatment Facility ○ Cardiac Rehabilitation ○ Chiropractic Services ○ Clinic Services ○ Dental Services (Adult and Children) ○ Drug Free Mom and Babies Program ○ Drug Screening ○ Early and Periodic Screening, Diagnoses, and Treatment ○ Family Planning Services and Supplies ○ Children with Special Health Care Needs Services | <ul style="list-style-type: none"> ○ Home Health Care Services ○ Hospice Care Services ○ Hospital Services, Inpatient ○ Hospital Services, Inpatient – Behavioral Health and Substance Use Stays ○ Hospital Services, Outpatient ○ Inpatient Psychiatric Services for Persons Under 21 Years ○ Inpatient Psychiatric Services for Persons Aged 21-64 Years ○ Inpatient Rehabilitation ○ Laboratory and X-Ray Services, Non-Hospital ○ Nurse Practitioner Services ○ Occupational Therapy ○ Physical Therapy | <ul style="list-style-type: none"> ○ Physician Services ○ Podiatry Services ○ Private Duty Nursing ○ Prosthetic Devices and Durable Medical Equipment ○ Psychological Services ○ Pulmonary Rehabilitation ○ Right From the Start Services ○ Rural Health Clinic Services (including Federally Qualified Health Centers) ○ Speech Therapy ○ Substance Use Disorder (SUD) Services ○ Tobacco Cessation Programs ○ Transportation, Emergency ○ Vision Services |
|---|---|--|

Drug Free Mom and Baby Programs (DFMB)

The DFMB program is a comprehensive maternity and behavioral health care program for pregnant and postpartum individuals with an opioid use disorder (OUD) diagnosis or a history of opioid use. The program transferred from grant funding to Medicaid in January 2022. The program supports these individuals with OUD by coordinating treatment and recovery plans throughout pregnancy and up to one year postpartum. DFMB staff refer enrollees to services for any identified social service needs including, but not limited to the Women, Infants, and Children program; housing assistance; food pantries; and transportation services.

Care Coordinators

Conduct the initial screening and development of treatment plan.

Community Health Workers (CHW)

Act as a bridge between the mom/infant in the community and the care coordinator in the office setting.

Peer Recovery Support Specialists

Play a supportive role to the member with life experience.

Obstetrics and Gynecological Providers

Perform routine prenatal and postpartum care for the member. They may provide medication-assisted treatment services.

Care Coordination Services

Medicaid enrollees participating in the DFMB Program must work with DFMB care coordinators at designated DFMB sites for services.

- Comprehensive Needs Assessment and Re-Assessment (as needed).
- Development and Update of Individualized Plan of Care.
- Care Coordination.
- Health Education and Promotion.
- Monitoring and Follow-Up.

The MCO's care coordinators work collaboratively with the enrollee's assigned DFMB care coordinator. The MCO remains responsible for coordination of all other Medicaid covered services available to the enrollee. As part of care coordination services, DFMB care coordinators, DFMB CHWs, and the MCO's care coordination staff work together to provide referral sources, re-engage DFMB participants at risk for loss of engagement, and collaborate in addressing the findings from health-related social needs screenings.

To view the Drug Free Mom and Baby policy, visit:

https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Appendices/Policy_Chapter%20521B.pdf

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Managed Care Organization Profile | 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. For more information on the NCQA accreditation process, visit <https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/>.

Health Plan Ratings are different than accreditation. A plan's overall rating is the weighted average of the plan's Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measurement ratings. Plans also earn bonus points for current accreditation. For more detailed information on plan ratings and a full report on each Health Plan (MCO), visit <https://reportcards.ncqa.org/health-plans?filter-plan=Medicaid&pg=1&dropdown-state=West%20Virginia&filter-state=West%20Virginia>.



Managed Care Organization	NCQA Accredited	Overall Rating
Aetna Better Health of West Virginia	Yes	4
The Health Plan	Yes	3.5
UniCare Health Plan of West Virginia	Yes	4

West Virginians interested in MCO health plan ratings are encouraged to review all MCO ratings and rating methods by visiting the NCQA website listed above. The NCQA website explains in detail the evaluation methods used and the significance of each point of analysis.

*5-Point Scale (1 = lowest performance / 5 = highest performance)

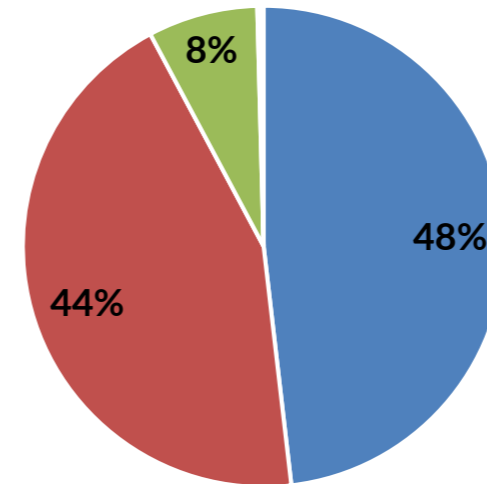
Top Accomplishments

- ABHWW implemented new mobile platform technology to increase member engagement by first addressing issues of “loneliness.” The service includes both mobile application and live-person outreach to the member. The goal of the service is to offer non-clinical outreach to members to get them engaged, and then encourage the member with other services that might be needed.
- ABHWW donated \$6.2M which includes, but is not limited to:
 - St. Mary’s Medical Center: \$1.5M endowment to establish a scholarship fund to increase class sizes for the St. Mary’s Nursing School.
 - Community Health Worker (CHW) Program: Expansion of the CHW program initiated by Marshall Health.
 - Facing Hunger Food Boxes: Funding to enhance and expand the Facing Hunger specific condition food box program that addresses nutritional needs of people with diabetes and renal disease within Cabell County and surrounding areas. The project will provide 200 food boxes for people with renal disease and 300 food boxes for people with diabetes. Each patient will receive a food box once per month over a three-year period.

Membership

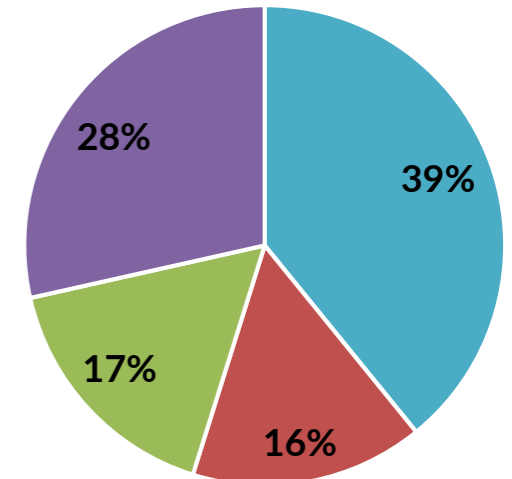
As of June 2022, ABHWW had **172,811** total members, representing **35.4%** of the MHT-Medicaid population.

Enrollment by Eligibility Group



- TANF
- Expansion
- SSI
- Pregnant Women*
- CSHCN*

Enrollment by Age Group



- <20
- 20-29
- 30-39
- 40+

Data Source: MHT encounter data through June 30, 2022, as of September 2022.
*Populations with <1% are not shown in the pie charts.

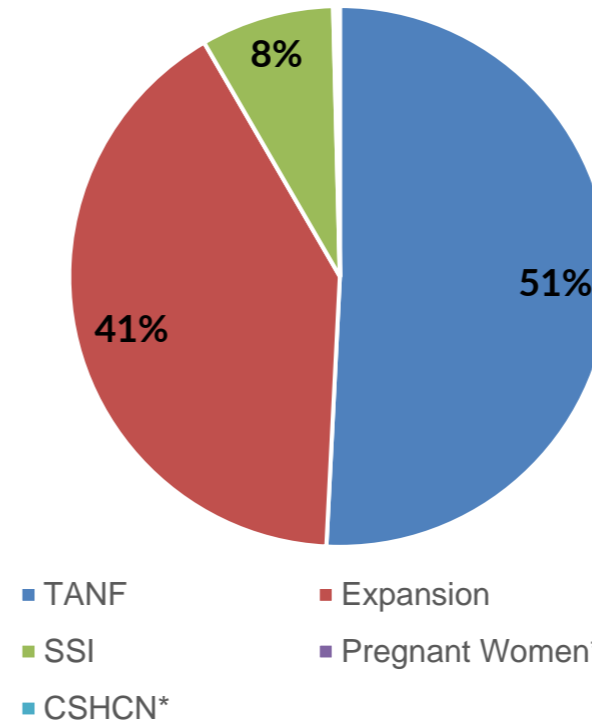
Top Accomplishments

- UniCare awarded 17 grants totaling \$1.5M, nine in collaboration with the Herbert Henderson Office of Minority Affairs. These grants were part of an initiative to improve health equity and reduce social determinants of health (SDOH) barriers. Included in the funding opportunities were diabetic retinal exam cameras for rural communities, workforce development, vocational training, job readiness, adolescent mental health, and health literacy.
- UniCare funded the WV Perinatal Partnership to provide access to doulas, especially in vulnerable populations, as well as scholarships for doula training and certification. Additionally, the grant established a state doula registry, provides rounds for the labor and delivery units to reduce stigma, data collection, and provides funding for reimbursement of doulas. In the first half of 2022, more than 28 doulas had received education and training, more than doubling the number of doulas in WV.
- UniCare conducted more than 1,000 outreach, education, and engagement activities, including contributing basic care items and funds to food, hygiene, and baby pantries throughout WV; supporting schools by supplying three school-based hygiene closets and sponsoring four re-pack the backpack events serving 650 children; donating 6,500 COVID-19 test kits to non-profits including homeless and domestic violence shelters in counties with high positive testing rates; and sponsoring community health and wellness events such as lead screenings, COVID testing, and vaccinations.

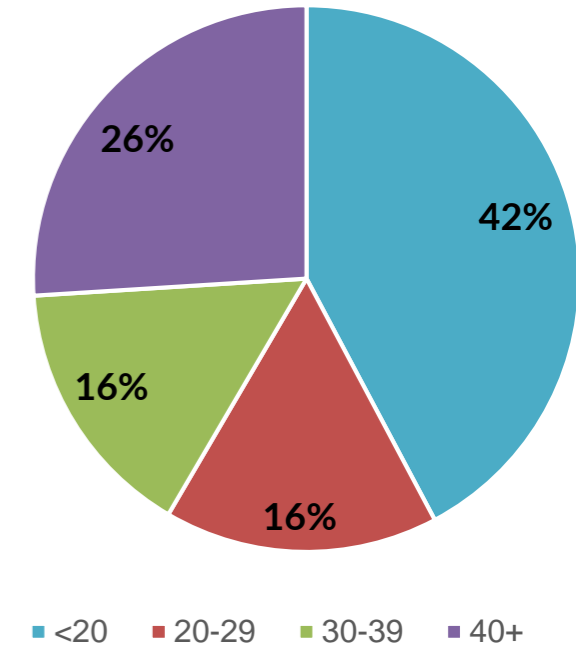
Membership

As of June 2022, UniCare of West Virginia had **191,599** total members, representing **39.20%** of the MHT-Medicaid population.

Enrollment by Eligibility Group



Enrollment by Age Group



Data Source: MHT encounter data through June 30, 2022, as of September 2022.

*Populations with <1% are not shown in the pie charts.

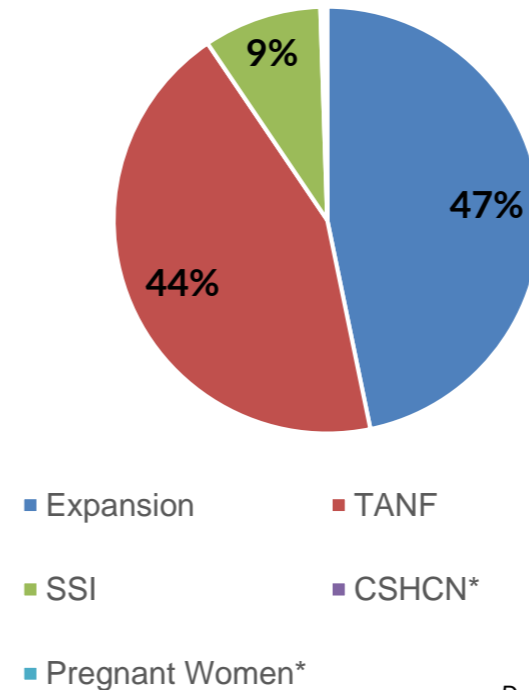
Top Accomplishments

- THP established two Member Experience Representative positions and a Member Engagement Manager position to help identify areas of improvement and make the THP member experience most meaningful.
- THP hired two life coaches that focus on assisting members with SDOH needs, job searches, resume development, budgeting, and other life skills.
- THP maintained ongoing partnerships with YWCA, Health Right, Food Pantries, Mon Health Mobile Nursing Lab (\$400,000), and West Virginia University's Critical Care Trauma Institute's Fresh Tissue Training Lab (\$1.5M).
- In SFY21, THP added four new face-to-face Transition of Care (TOC) Navigators who were dedicated to helping members with care coordination and the transition from behavioral health facility treatments to outpatient services. This program is now inclusive of a pilot project with four SUD facilities to complete health risk assessments on members prior to discharge. TOC staff help to facilitate the completion of these forms for clinical staff.

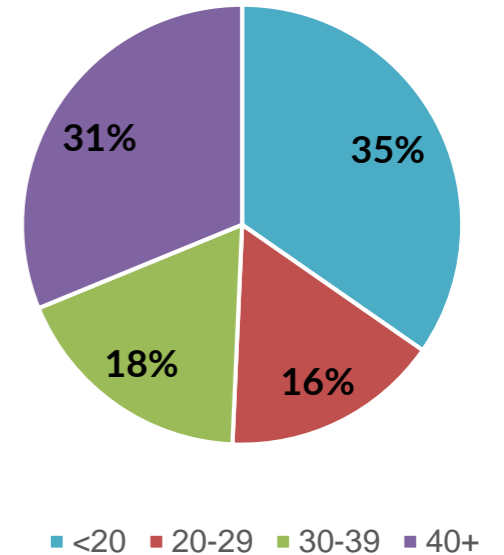
Membership

As of June 2022, THP had **123,995** total members, representing **25.4%** of the MHT-Medicaid population.

Enrollment by Eligibility Group



Enrollment by Age Group



Data Source: MHT encounter data through June 30, 2022, as of September 2022
*Populations with <1% are not shown in the pie charts.

Annual Technical Report

Core components of the BMS mission focus on ensuring the medical services purchased for members receiving Medicaid benefits are high quality, easily accessible, and effective when provided.

Each year, the BMS's External Quality Review Organization (EQRO) vendor, Qlarant Quality Solutions, conducts an independent review to assess the compliance of West Virginia's Medicaid program. During this process, Qlarant examines the performance of the program to identify strengths and any areas for improvement. The external review focuses on areas such as service quality, service accessibility, and whether services are provided by MCOs in a time-appropriate manner.

When the EQRO completes its evaluation, BMS publishes an Annual Technical Report explaining its findings and describing how well the State has run the Medicaid program.

External Quality Review Conclusions

Qlarant's evaluation found that West Virginia's managed care programs continue to make strides and improve the quality of, and access to, health care services for its Medicaid members.

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.

Using appropriate comparison weighting, Qlarant determined that West Virginia's MCOs performed favorably to national average benchmarks in 69% of HEDIS measures and 54% CAHPS measures.

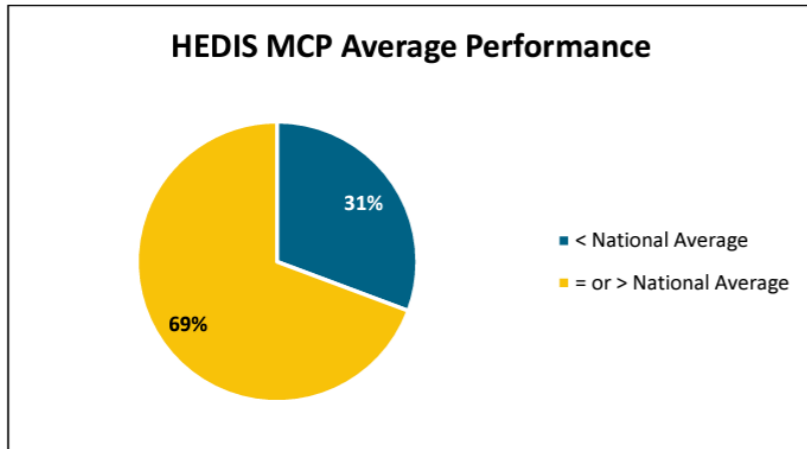
To view the full Annual Technical Report, visit:

https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/WV%202021%20ATR_FINAL%20508.pdf

HEDIS Measures

HEDIS is a comprehensive set of standardized performance measures designed by NCQA to provide consumers with information they need to compare health plan performance. The HEDIS performance measures included in the EQRO report include select 2021 (Measurement Year [MY] 2020) results for each managed care plan in West Virginia.

The MCOs, based on weighted averages, performed better than the national average benchmark for 69% of HEDIS measures reported in Appendix 1 in the EQRO report. West Virginia's weighted averages were compared to the NCQA Quality Compass Medicaid health management organization (HMO) benchmarks.



ABHWV's HEDIS measure rates reflect performance in all Medicaid populations (MHT and MHP) per NCQA reporting requirements.

WV HEDIS Compared to the NCQA Quality Compass Medicaid HMO 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 HMO benchmarks. Two diamonds represents the managed care plan weighted average is equal to or exceeds the NCQA Quality Compass national Medicaid HMO average, but does not meet the 75th percentile. Three diamonds represents the managed care plan weighted average is equal to or exceeds the NCQA Quality Compass 75th percentile for Medicaid HMO. The table below displays the number of measures by HEDIS domain that received either two or three diamonds.

HEDIS Domain	Number of Measures Reported in Appendix 1 of the EQRO report with a MCO weighted average that equals or exceeds the NCQA Quality Compass National Medicaid HMO Average
Effectiveness of Care Domain	55 (out of 81)
Access and Availability Domain	12 (out of 14)
Utilization	3 (out of 6)

Some measures in the EQRO report do not have a comparison (no benchmark available) and were excluded from the counts above.

To view HEDIS Measures from the EQRO report, visit:

https://dhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/WV%202021%20ATR_FINAL%20508.pdf

In addition to the Annual Technical Report, which provides independent, external review of MCO health plan quality and performance, 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.

2021 Managed Care Annual Report for the Legislative Oversight Committee on Health and Human Resource Accountability (LOCHHRA)

The Managed Care Report to LOCHHRA is required by West Virginia Code Section 9-5-22 and is designed to provide legislators with information regarding multiple aspects of the managed care program. In addition to overall quality assurance insights, this report provides a more holistic view of West Virginia's Medicaid program, giving legislators the information needed to craft healthier tomorrows for the state's most vulnerable individuals and families.

View the full report, visit:

https://dhhr.wv.gov/bms/Members/Managed%20Care/Documents/BMS_2021_HB4217%20Reportfinalsh4422.pdf

West Virginia Bureau for Medical Services Archived Managed Care Reports

The DHHR website hosts many archived reports for public review. These reports provide historical insight into different components of the managed care program.

To view enrollment figures, quality reports, legislative reports, and past annual reports, visit:

<https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Pages/default.aspx>

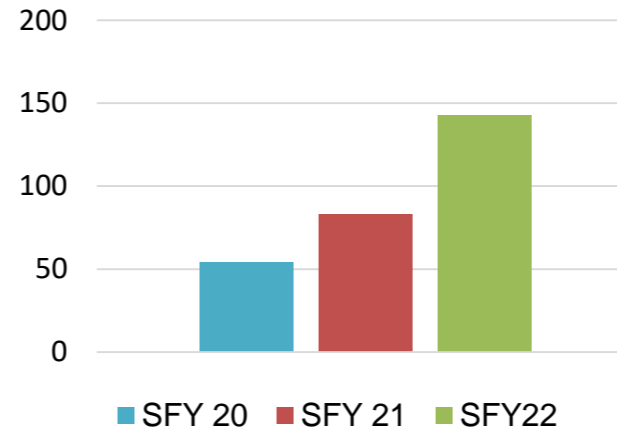
Program integrity efforts act as a gatekeeper to safeguard the Medicaid program. Multiple anti-fraud systems work together to ensure Medicaid services are administered correctly and public funds are safeguarded from fraud and misuse.

Throughout SFY2022, BMS observed continued dedication among participating Medicaid MCOs related to program integrity oversight. During this time period:

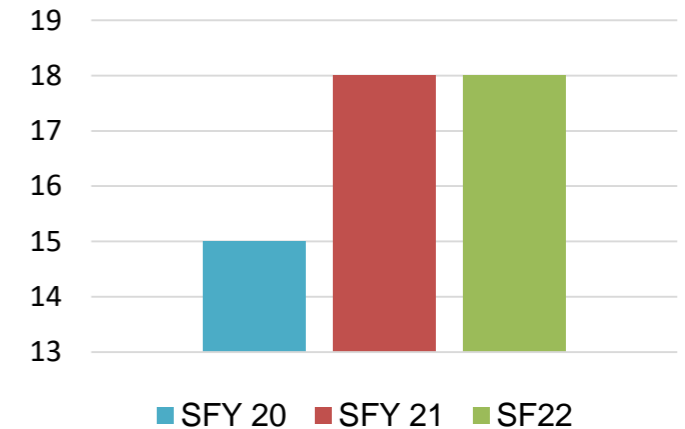
- New program integrity audits increased **72%**.
- Cases referred as fraud remained consistent with no change.
- Overpayment recoveries decreased **56%**.

The MCOs continue to collaborate with BMS to maintain or increase program integrity activities through fraud, waste and abuse prevention, new audits, and fraud referrals. The SFY22 decrease in overpayment recoveries should not minimize the MCO's commitment to program integrity and may be a result of improved controls, policy changes and preventative measures, MFCU investigation, provider appeals, or other non-MCO-related circumstances. The successful partnership between BMS and MCO special investigation units is increasing Medicaid program integrity and decreasing the success rate of fraud.

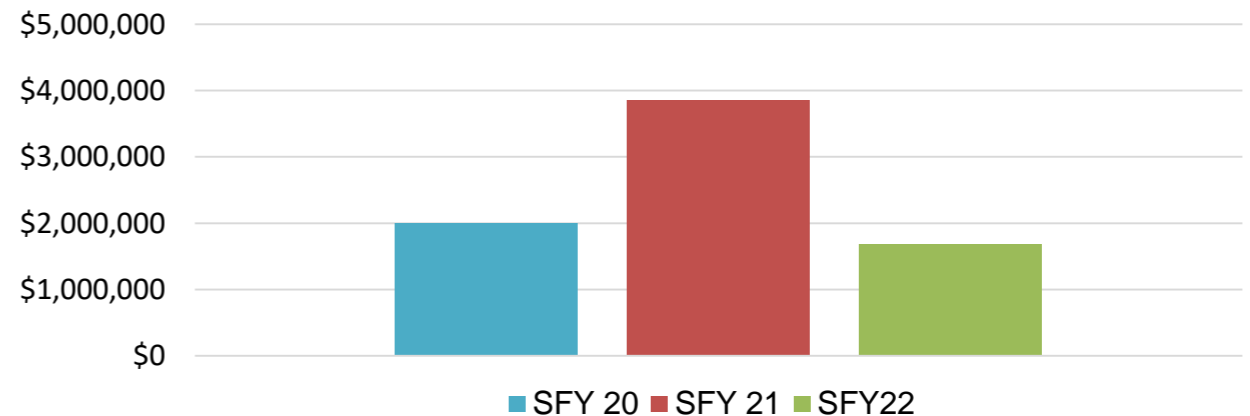
New Audits Initiated



Fraud Referrals Made



Overpayment Recoveries



Program Overview: Who Pays for Medicaid?

- <https://www.medicaid.gov/medicaid/financial-management/index.html>
- <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Program Overview: Continuing to Address COVID-19 – COVID-19 Resources

- <https://data.cdc.gov/Vaccinations/COVID-19-Vaccinations-in-the-United-States-Jurisdiction/unsk-b7fc>
- https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fvaccines%2Fkeythingstoknow.html
- <https://dhhr.wv.gov/COVID-19/Pages/default.aspx>

Program Overview: Public Health Emergency Unwind Resources

- <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>
- <https://www.kff.org/report-section/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey-executive-summary/?msclkid=9c3b6bc9cbd411eca36760ba7d9205cb>

Managed Care Program: Drug Free Mom and Baby Programs

- https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Appendixes/Policy_Chapter%20521B.pdf

Managed Care Organization Profile: Accreditation

- <https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/>
- <https://reportcards.ncqa.org/health-plans?filter-plan=Medicaid&pg=1&dropdown-state=West%20Virginia&filter-state=West%20Virginia>

Quality Assurance: External Quality Review

- https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/WV%202021%20ATR_FINAL%20508.pdf

Quality Assurance: Other Medicaid Reports

- https://dhhr.wv.gov/bms/Members/Managed%20Care/Documents/BMS_2021_HB4217%20Reportfinalsh4422.pdf
- <https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Pages/default.aspx>

Quality Assurance: CMS Adult and Child Core Set

- <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html>
- <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>

Explore These Government Websites

West Virginia Bureau for Medical Services

<https://dhhr.wv.gov/bms>

West Virginia Department of Health & Human Resources

<http://www.dhhr.wv.gov>

Centers for Medicare & Medicaid Services

<https://www.cms.gov>

Medicaid.gov

<https://medicaid.gov>

West Virginia DHHR Local Field Offices

<https://dhhr.wv.gov/bms/Pages/Field-Offices.aspx>

Need to Apply for Medicaid?

You can apply online through the Health Insurance Marketplace at www.healthcare.gov.

If you have questions, you can call the federal call center 24/7 at 1-800-318-2596 or TTY: 1-855-889-4325.

You may also apply for Medicaid and other DHHR programs at www.wvpath.org.

To apply over the phone, call the Customer Service Center at 1-877-716-1212.

For additional information on applying in person or mailing in a paper application, please contact your local DHHR office. You can use the web link to the left to find the local field office nearest you.

Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
Phone: (304) 558-1700

Contact BMS: <https://appengine.egov.com/apps/wv/dhhr/bms/contactus>

UniCare Health Plan of West Virginia, Inc.

200 Association Drive, Suite 200
Charleston, WV 25311
www.unicare.com

Aetna Better Health of West Virginia, Inc.

500 Virginia Street East, Suite 400
Charleston, WV 25301
www.aetnabetterhealth.com/westvirginia

The Health Plan, Inc.

1110 Main Street
Wheeling, WV 26003
www.healthplan.org