



West Virginia Medicaid

Mountain Health Promise 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 (SSA)**. 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 that 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>

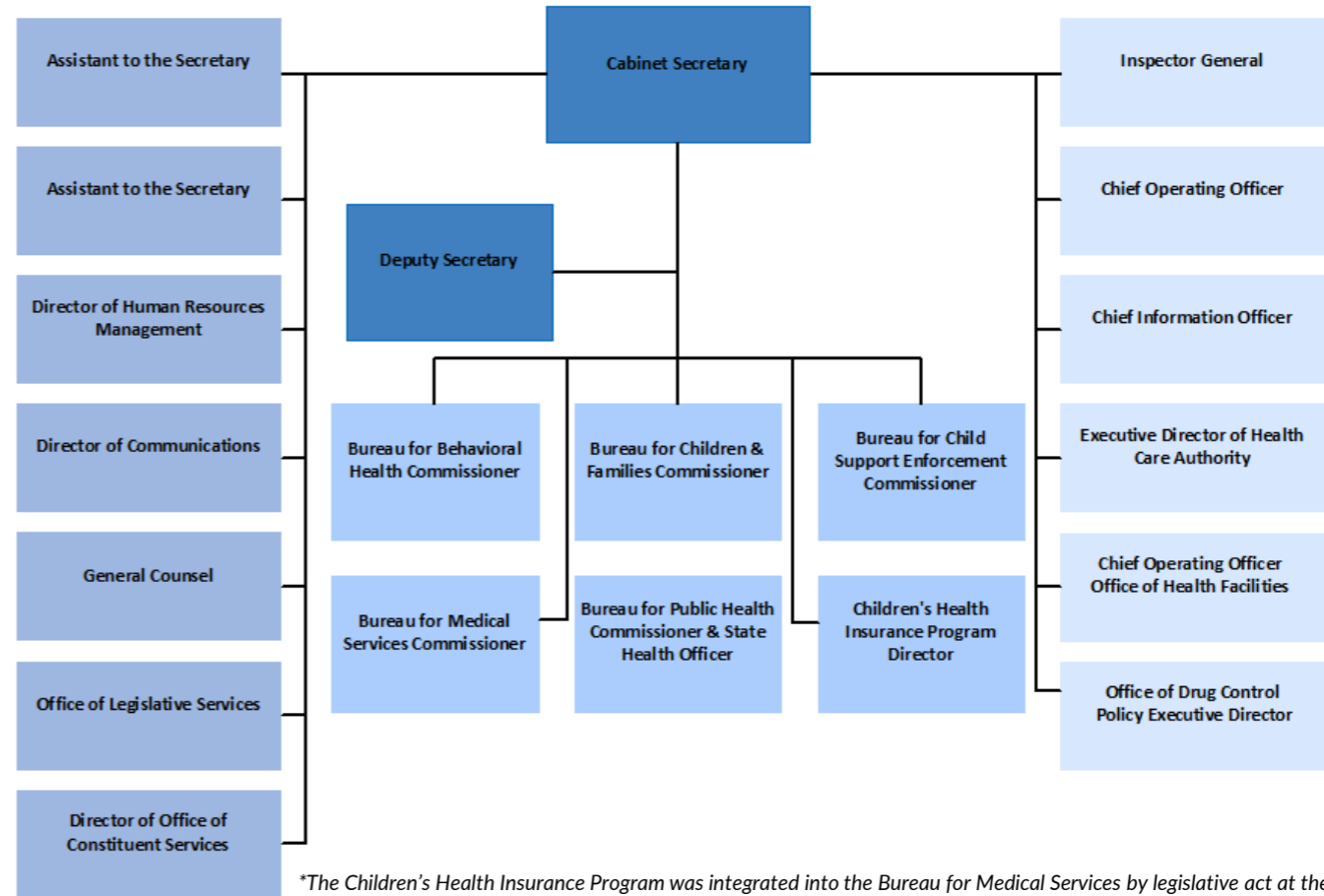
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Program Overview | West Virginia DHHR

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 individuals they serve.

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

The Department 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 (BSS), the Bureau for Medical Services (BMS), and the Bureau for Public Health. In total, the Department employs over 6,000 individuals statewide.

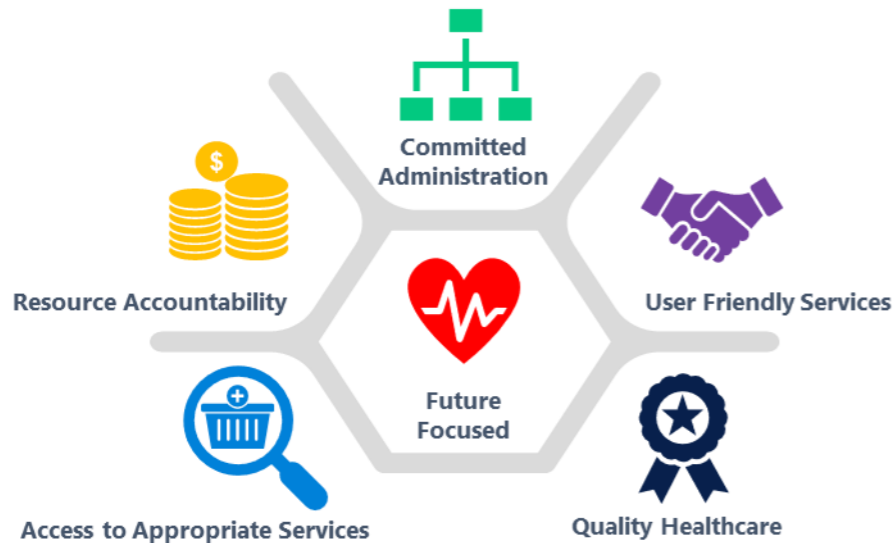


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Program Overview | West Virginia Medicaid

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 a managed care organization (MCO) 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 (FFS) 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 one MCO through the Mountain Health Promise (MHP) program – Aetna Better Health of West Virginia (ABHWV).

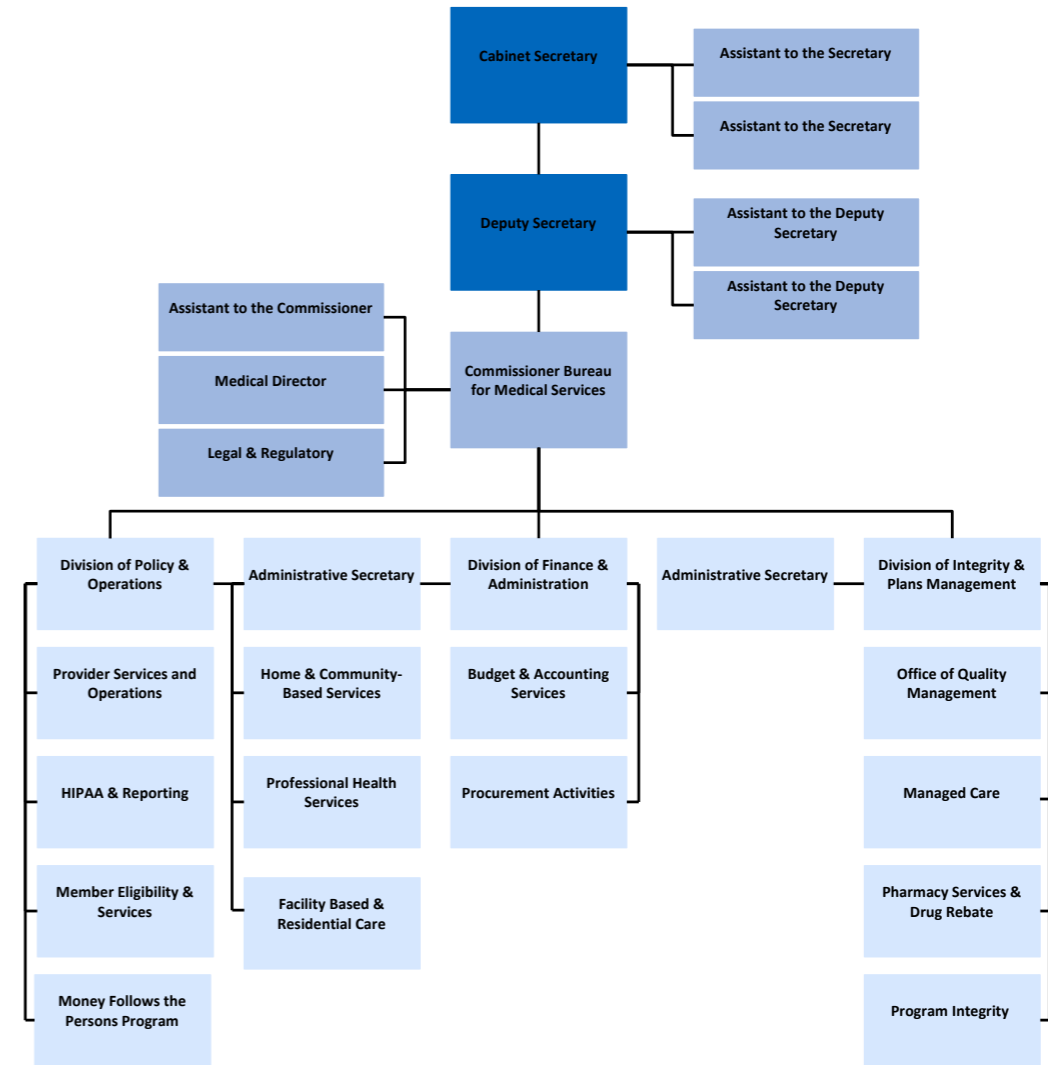
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Program Overview | West Virginia BMS

As the single state Medicaid agency, BMS is also responsible for establishing and administering 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.

The Office of Managed Care within BMS oversees MHP. Medicaid managed care members in the MHP program are currently enrolled with ABHWV.

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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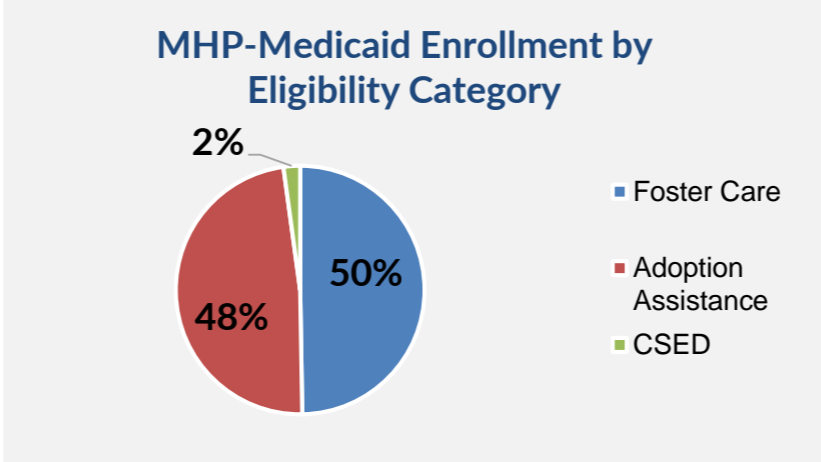
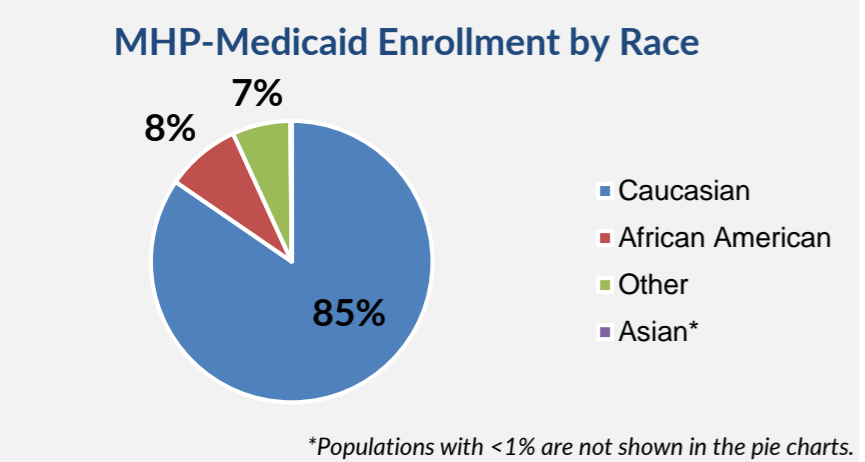
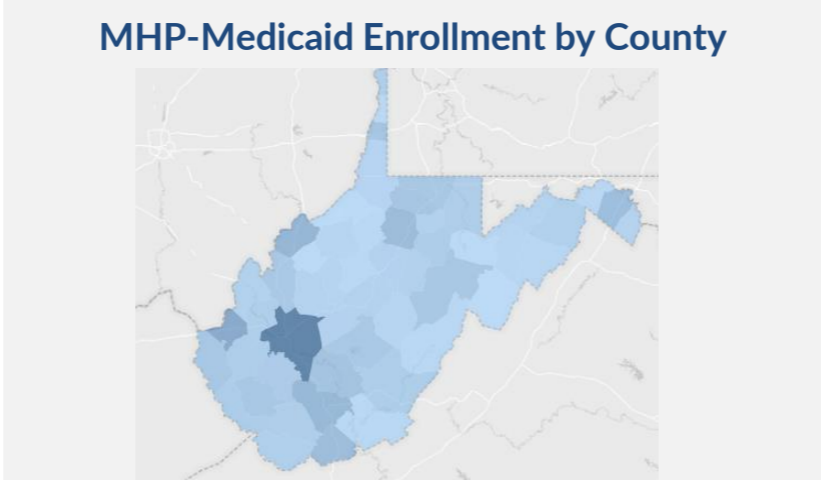
Program Overview | MHP Statistics

Demographics



WV Population | 1.78 Million

MHP-Medicaid Enrollment | 29,685



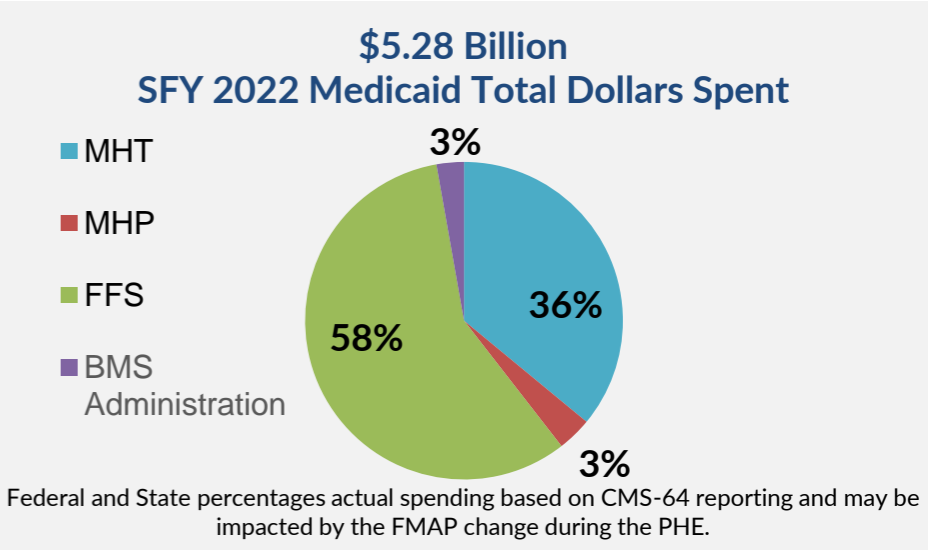
*Populations with <1% are not shown in the pie charts.

Data Sources: WV Census and MHP encounter data through June 30, 2022, as of September 2022.

Spending

\$185.4 Million Total MHP Expenditures in SFY 2022*	MHP accounts for 3% of total SFY 2022 Medicaid Spending
\$ 81% federal dollars	\$ 19% state dollars
Total Federal Spend	Total State Spend
\$150.5 million	\$34.9 million

*Includes \$15.9 Million total funds for the Children with Serious Emotional Disorder Waiver

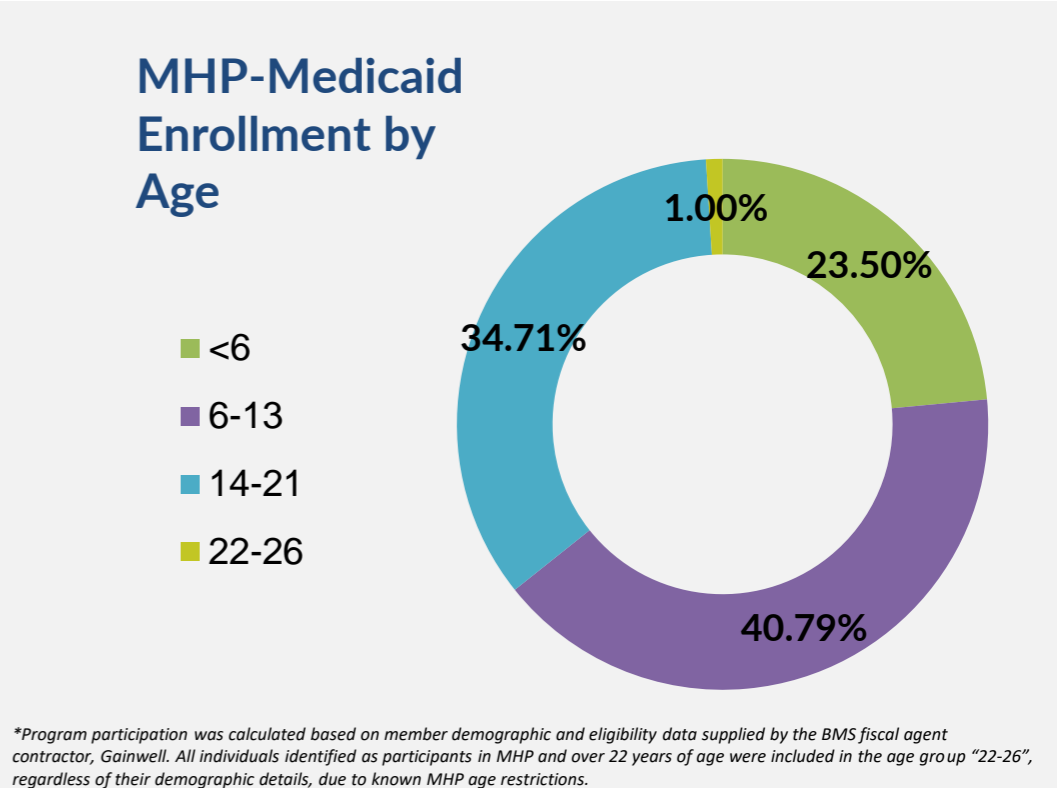
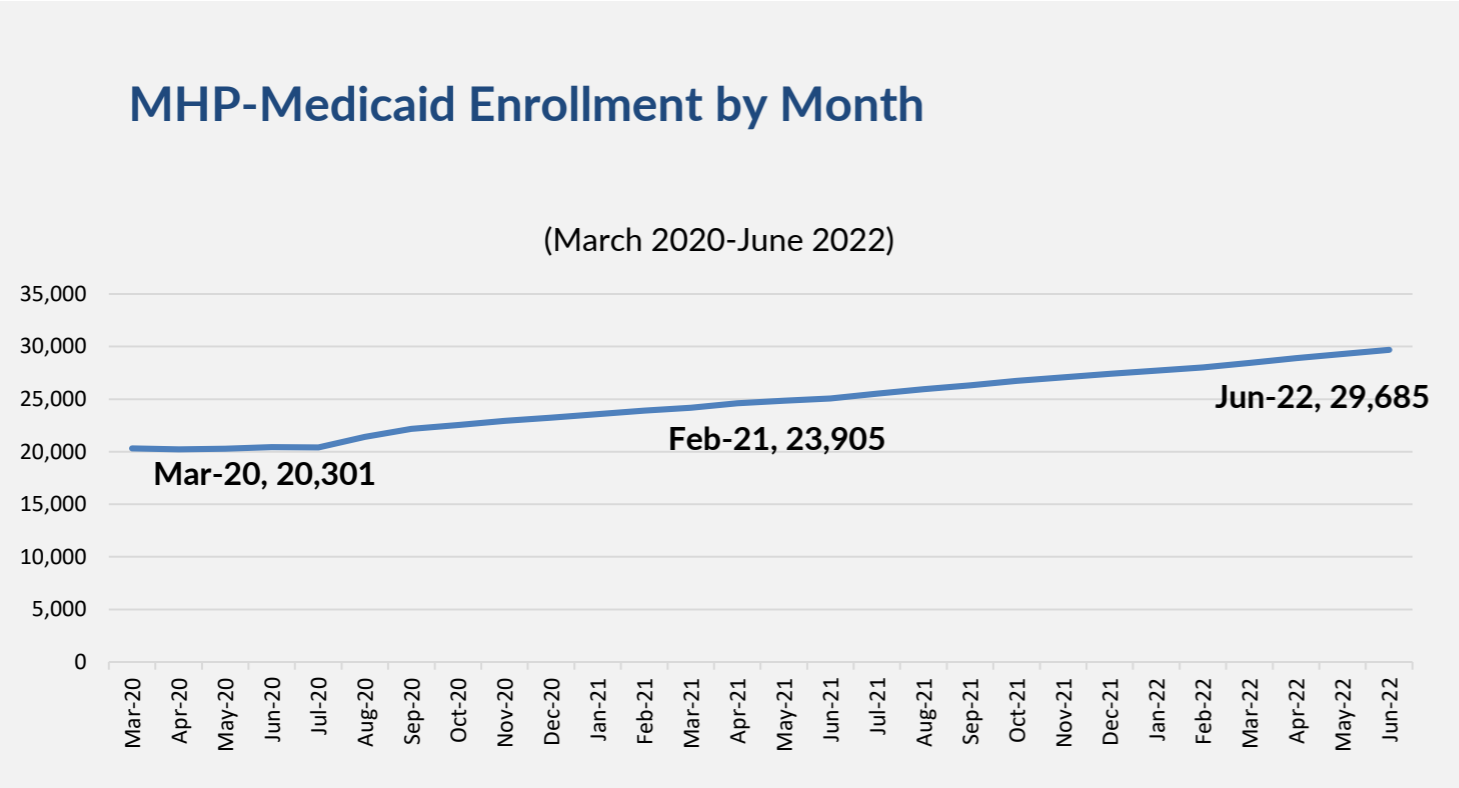


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Managed Care Program | MHP Membership Statistics

MHP-Medicaid Membership

The MHP-Medicaid program serves West Virginian children and youth in foster care and the adoption assistance program. The MHP program provides physical, dental, behavioral health, and socially-necessary services for children. As of June 2022, the total number of members enrolled was **29,685**.



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 to enrollees. 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 **2.8 million 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 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 the Children's Health Insurance Program (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 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 Through SFY22?

The State established the MHP program and contracted with MCOs in February 2020. In July of 2021, West Virginia submitted a request for a new 1915(b) waiver for MHP, formerly referred to as Specialized Managed Care Plan for Children and Youth. Every two years, states are required to renew their 1915(b) waivers and report program monitoring results on the prior waiver period.

CMS approved the MHP 1915(b) waiver through June 30, 2023. In this waiver period, the State will closely monitor the MHP program processes and policies to identify program and quality improvements.

What Details Were Changed in the 1915(b) Waiver Renewal?

As part of the 1915(b) waiver renewal, the State specified the parameters within which children could enroll in the specialized MCO. Children in foster care and adoption assistance will default into ABHWV. Once enrolled, the State will send families the date of MCO enrollment. If MCO enrollment is not preferred, families are given the option to disenroll and opt for FFS.

2 Health Delivery System | CSEDW

What Is a Medicaid 1915(c) Waiver?

The Children with Serious Emotional Disorder Waiver (CSEDW) is a Medicaid home and community-based services (HCBS) waiver program authorized under 1915(c). **Section 1915(c) of the SSA provides funding for states to furnish an array of HCBS that assist Medicaid beneficiaries to live in their community and avoid institutionalization.** To implement HCBS, a state must submit a 1915(c) waiver application to CMS for approval.

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

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

- Levels of Care.
- Waiver Administration and Operation.
- Participant Access and Eligibility.
- Participant Services.
- Participant-Centered Planning and Delivery.
- Participant Rights/Safeguards.
- Quality Improvement Strategy.
- Financial Accountability and Cost Neutrality.

What 1915(c) Waiver Activities Have Occurred Through SFY22?

The 1915(c) waiver is anticipated to reduce the number of children in both in-state and out-of-state psychiatric residential treatment facilities (PRTFs) and shorten the length of stay for those in acute care. This CSEDW will permit the state to provide HCBS that would allow children ages 3-21 to remain in their homes and communities.

In June, CMS approved the State's request to amend their 1915(c) waiver with an effective date of July 1, 2022.

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

With implementation of the approved waiver, BMS has been approached by stakeholders to consider amending the waiver in order to more closely align with the National Wraparound Initiative model. Implementation of the waiver began right before the beginning of the COVID-19 pandemic. The State made some immediate waiver changes through a Section K waiver amendment, which included requiring providers to submit initial and master care plans within seven and 30 days, respectively, from the day they receive the referral, instead of the date of slot release. The other proposed changes in this waiver amendment sought to align the waiver with the State's wraparound initiative by improving linkages between services to facilitate services at the most clinically appropriate level of care.

3 Managed Care Program | Introduction

What is MHP?

BMS implemented MHP, formerly referred to as Specialized Managed Care Plan for Children and Youth, through a new 1915(b) waiver effective March 1, 2021. **The MHP program serves Medicaid beneficiaries who are in foster care or receive adoption services and qualifying children with serious emotional disorders.** The program provides comprehensive physical and behavioral health services, children's residential care services, and socially-necessary services administration. Additional support is provided to the MHP population through coordination with DHHR's BSS and the Foster Care Ombudsman (FCO).

As the sole contractor for MHP, **ABHWV** is responsible for coordinating physical, behavioral, dental, and socially-necessary services for each enrolled child. Each enrollee has a primary care provider that acts as their medical home. The medical home promotes better quality, more patient-centered care by providing a continuous source of care that is coordinated and accessible to the member.

Background of MHP

MHP is a full-risk managed care program that serves approximately 29,685 children and youth across the state. Members eligible for CSEDW are automatically enrolled in MHP. **The MHP program runs concurrently with the State's CSEDW 1915(c) waiver to allow BMS to provide HCBS and the Section 1115 Substance Use Disorder (SUD) Waiver to allow enrollment into one specialized MCO.**

MHP Program Goals

Reduce fragmentation and offer a seamless approach to participants' needs.

Deliver needed supports/services in an integrated and cost-effective way.

Provide a continuum of acute care services.

Implement a comprehensive quality approach across the continuum of care services.

The following list includes covered services for the MHP program.
(This list is not exhaustive and is subject to change. Always verify coverage with your MCO/Health Plan prior to service.)

Medical Services

- Ambulatory Surgical Center Services
- Cardiac Rehabilitation
- Children's Residential Services
- Chiropractor Services
- Clinic Services
- Early and Periodic Screening, Diagnoses and Treatment
- Emergency Shelter Services
- Family Planning Services and Supplies
- Handicapped Children's Services/Children and Youth with Special Health Care Needs Services
- Home Health Care Services
- Hospice
- Hospital Services, Inpatient
- Hospital Services, Outpatient
- Inpatient Rehabilitation

- Laboratory and X-Ray Services, Non-Hospital
- Nurse Practitioners' Services
- Other Services (Speech Therapy, Physical Therapy, Occupational Therapy)
- Physician Services
- Podiatry Services
- Private Duty Nursing
- Prosthetic Devices and Durable Medical Equipment
- Pulmonary Rehabilitation
- Right from the Start Services
- Rural Health Clinic Services, including Federally Qualified Health Centers
- Tobacco Cessation
- Transportation, Emergency
- Vision Services

Dental Services

- Adult and Children

Behavioral Services

- Behavioral Health Rehabilitation for Individuals Under Age 21, PRTF
- Behavioral Health Outpatient Services
- Psychological Services
- Hospital Services, Inpatient - Behavioral Health and Substance Abuse Stays
- Inpatient Psychiatric Services for Individuals Under Age 21
- Drug Free Mom and Babies Program
- Drug Screening
- Serious Emotional Disturbance Waiver Services
- SUD 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 those 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	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.

ABHWV'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 community health workers, and the ABHWV'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

What is the DOJ Settlement Agreement?

The Department of Justice (DOJ) settlement involves the services, programs, and activities offered to children with serious mental health conditions through DHHR and other state agencies. On June 1, 2015, the DOJ notified West Virginia that it does not comply with Title II of the Americans with Disabilities Act. This agreement between the DOJ and DHHR addresses the allegations regarding DHHR's service system for children with serious mental health conditions. West Virginia committed to reforming their child welfare system and to ensuring children could receive mental health services in the most integrated setting appropriate to meet their needs.

DHHR committed to preventing children with serious mental health conditions from being needlessly removed from their family homes in order to obtain treatment, prevent those children from unnecessarily entering residential mental health treatment facilities, and transition children who have been placed in these settings back to their family homes and communities. It is the goal of DHHR to ensure children covered by this agreement receive sufficient community-based services to prevent unnecessary institutionalization. Successful reform will reduce the number of children unnecessarily placed in residential mental health treatment facilities and the length of stay for children at these facilities.

Who Is the Target Population?

All children under the age of 21 who:

- Have a serious emotional or behavioral disorder or disturbance that results in a functional impairment, and (1) are placed in a residential mental health treatment facility, or (2) reasonably may be expected to be placed in a residential mental health treatment facility in the near future.
- Meet the eligibility requirements for mental health services provided or paid for by DHHR.

In-Home and Community-Based Services

DHHR is committed to providing timely access to in-home and community-based services sufficient to meet the individual's needs, including:

- Wraparound Facilitation.
- Behavioral Support Services.
- Children's Mobile Crisis Response.
- Therapeutic Foster Family Care.
- Assertive Community Treatment.

Children's Residential Care Overview

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. Prioritizing in-state placements for residential care services is a goal of the MHP program.

Average Length of Stay Calculation

Monthly average length of stay (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 following table details the ALOS for MHP members in in-state and out-of-state residential care centers and group homes by month. The out-of-state data reported by ABHWV was collected from case management and utilization management reports used within their organization. If members appeared on multiple reports, data that was most complete and showed the longest ALOS for those members was used.

ALOS for Members in In-state and Out-of-state Resident Care Centers and Group Homes by Month

One programmatic goal of the MHP program is to prioritize in-state placements for child residential care services. The table below details the ALOS for MHP members in in-state and out-of-state residential care centers and group homes by month from March 2021 through February 2022.

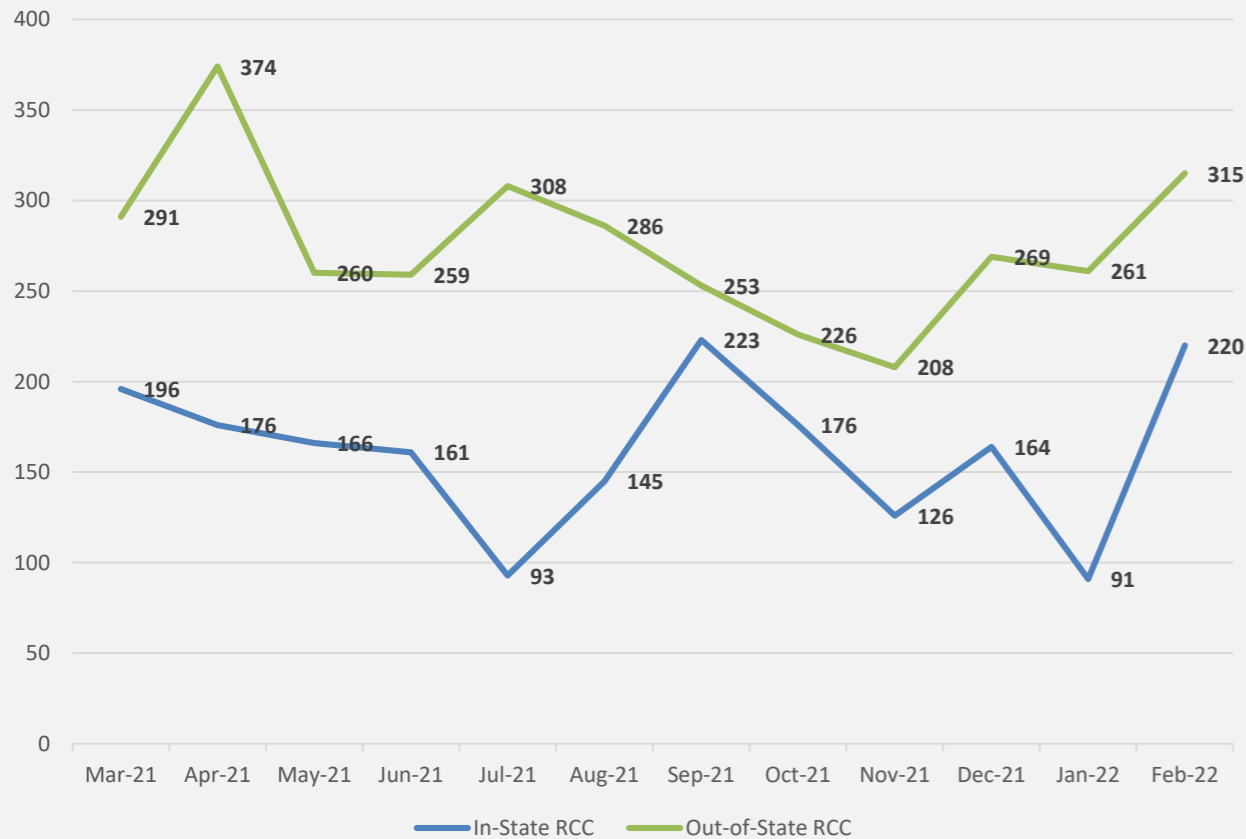
	In-State Facilities		Out-of-State Facilities	
	ALOS in Residential Care Centers	ALOS in Group Homes	ALOS in Residential Care Centers	ALOS in Group Homes
March 2021	196	127	291	302
April 2021	176	111	374	356
May 2021	166	124	260	276
June 2021	161	152	259	321
July 2021	93	147	308	300
August 2021	145	141	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.

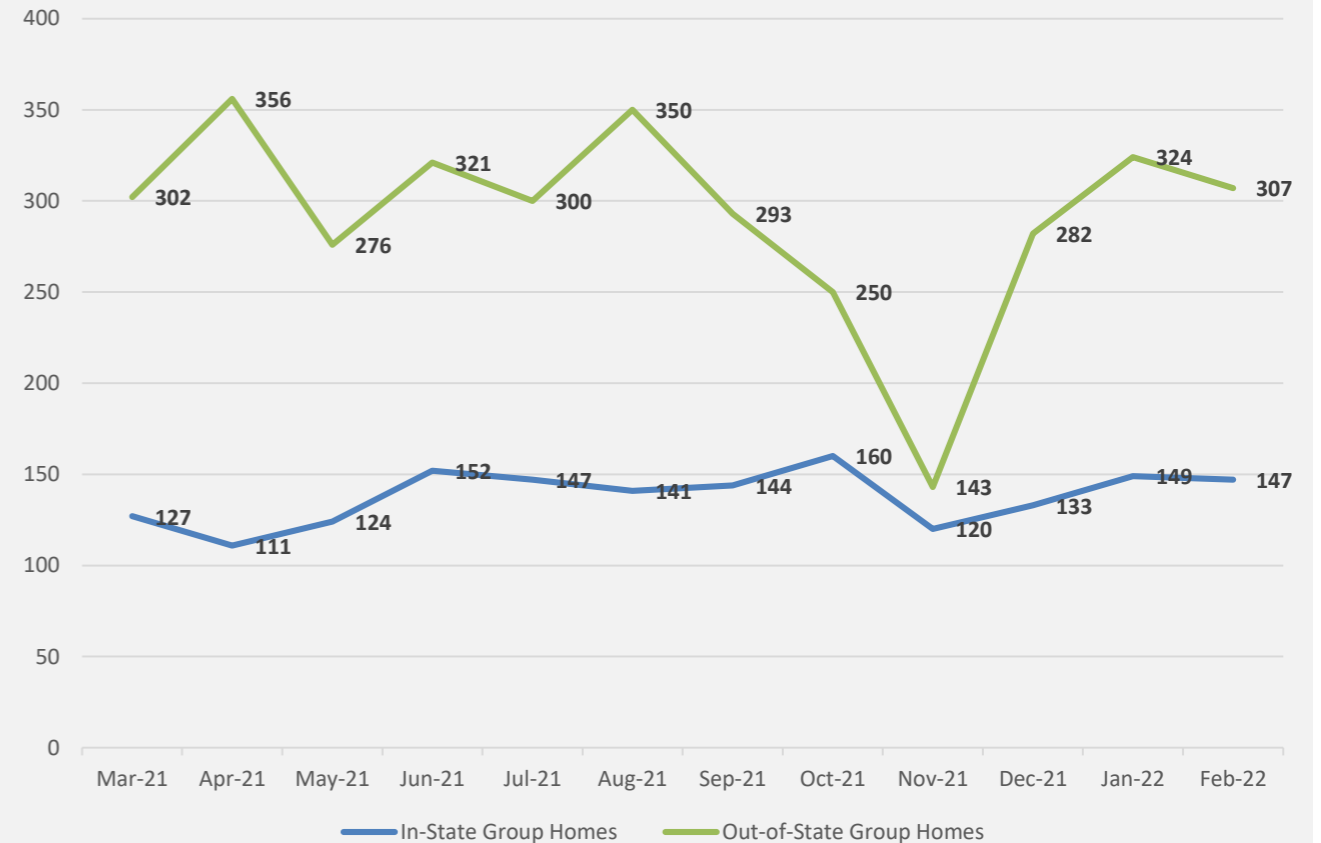
https://dhhr.wv.gov/bms/Members/Managed%20Care/MHP/Documents/MHP_Legislative%20Report%20c2%a79-5-27_%20FINAL%20%281%29.pdf

ALOS in Child Residential Centers by Month from March 2021 through February 2022

Comparison of Residential Care Centers



Comparison of Group Homes



https://dhhr.wv.gov/bms/Members/Managed%20Care/MHP/Documents/MHP_Legislative%20Report%20%20c2%a79-5-27_%20FINAL%20%281%29.pdf

4

MCO 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*	Distinction**
ABHWV	Yes	4	Electronic Clinical Data

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

** Electronic Clinical Data distinction recognizes organizations that have an accepted rate for a non-publicly reported measure that leverages electronic clinical data and was originally introduced for the HEDIS ECDS Reporting Standard. For more information, please visit: <https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/>.

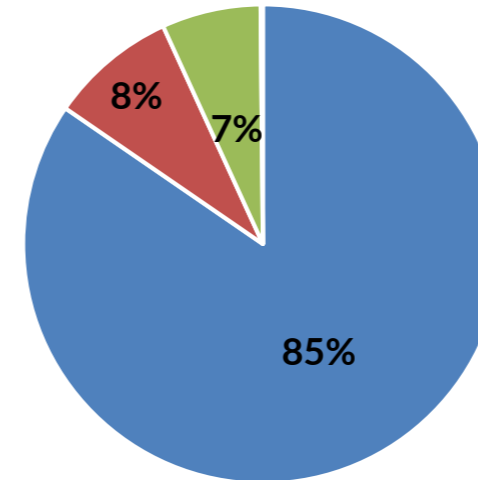
Top Accomplishments

- Maintained or improved the following HEDIS rates despite the ongoing challenges of the COVID-19 pandemic:
 - Lead screening for children.
 - Immunizations for adolescents (Combination 2) including Meningococcal, TDAP/TD, and HPV.
 - Prenatal and postpartum care – timeliness of prenatal care and postpartum care.
- Reinvested \$11 million into supporting further development and expansion of intensive community-based services and in-state residential programs. Phase I included 19 residential, foster care, and shelter providers who contractually agreed to the expansion of their services. This includes but is not limited to:
 - Expansion of specialized residential care for youth currently out of state, with an emphasis on youth on the spectrum, high-acuity trauma, and borderline IQ.
 - CSEDW development and expansion statewide.
 - Expansion of therapeutic foster care.
 - Expansion of community-based care and aftercare.
- Implemented a new outreach initiative to evaluate members' social determinants of health and provide them with community resource information and/or case management assistance as needed.

Membership

As of June 30, 2022, ABHWV had 29,685 members for the MHP program.

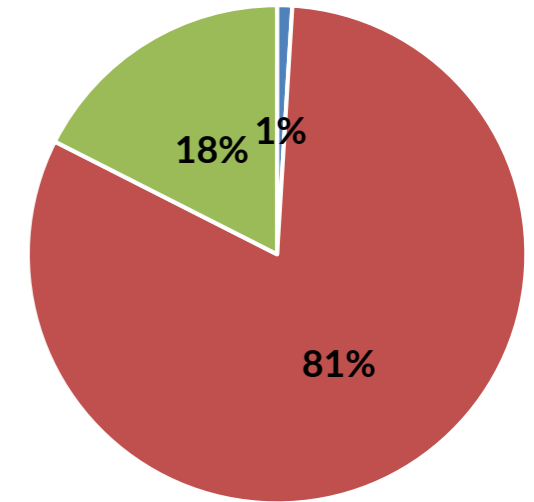
Enrollment by Race



■ Caucasian
■ Other

■ African American
■ Asian*

Enrollment by Ethnicity



■ Hispanic or Latino Origin
■ Not of Hispanic or Latino Origin
■ No Response

*Data Source: MHP encounter data through June 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 Medicaid enrollees 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 program performance 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

Performance Measures

The table to the right highlights MHP-specific performance measures available for Measurement Year (MY) 2020, covering March 2020 through December 2020. The table compares the ABHWV MHP results to the *Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set Chart Pack, November 2021*. Due to the MHP program implementation date of March 1, 2020, the number of performance measures available are limited.

All measures, except for *Prenatal and Postpartum Care: Timeliness of Prenatal Care*, include administrative data collection where rates are calculated using claims and other supplemental data. A hybrid data collection method is used to calculate *Prenatal and Postpartum Care: Timeliness of Prenatal Care* where the rate is calculated using administrative and medical record data.

To view MHP-specific performance measures, visit :

https://dhhr.wv.gov/bms/Members/Managed%20Care/MHP/Documents/MHP_Legislative%20Report%20%20c2%a79-5-27_%20FINAL%20%281%29.pdf

Performance Measure	MHP ABHWV MY 2020 Rate	Comparison to Benchmarks
Ambulatory Care: Emergency Department Visits – 0-19 Years (Visits per 1,000 Member Months) <i>Lower rate is better</i>	24.12	◆ ◆ ◆
Contraceptive Care-Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 3 Days	5.41%	◆ ◆ ◆
Contraceptive Care-Postpartum Women Ages 15-20 Long-Acting Reversible Method of Contraception, 60 Days	13.51%	◆
Contraceptive Care-Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 3 Days	5.41%	◆
Contraceptive Care-Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception, 60 Days	40.54%	◆
Dental Sealants for 6-9 Year Old Children at Elevated Risk	23.70%	◆
Follow-Up After Hospitalization for Mental Illness: 7 Days Follow-Up - Ages 6-7	57.29%	◆ ◆ ◆
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up - Ages 6-7	75.00%	◆ ◆
Percentage of Eligible (Children) that Received Preventive Dental Services	50.27%	◆ ◆ ◆
Prenatal and Postpartum Care: Timeliness of Prenatal Care***	86.36%	◆ ◆
<i>Diamond Rating System:</i>		
<i>MCO result is below the NCQA Quality Compass National Average.</i>		◆
<i>MCO result is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th percentile.</i>		◆ ◆
<i>MCO result is equal to or exceeds the NCQA Quality Compass 75th percentile.</i>		◆ ◆ ◆

5 Quality Assurance | Health Outcomes

Child CAHPS for Children with Chronic Conditions (CCC) Population Measures

The CAHPS survey assesses health care quality by asking patients to report their experiences with care. ABHWV's Child CAHPS for CCC Population survey was conducted to target MHP experiences. The data presented in the table to the right reflects survey measures and results for calendar year (CY) 2020. The table compares the ABHWV MHP results to the NCQA Quality Compass Medicaid HMO benchmarks.

HEDIS Measures

HEDIS is a comprehensive set of standardized performance measures designed to provide consumers with information related to health plan performance. The HEDIS performance measures included in Appendix 1 of the EQRO report include select 2021 (MY 2020) results for each managed care plan in West Virginia. ABHWV's HEDIS measure rates reflect ABHWV's combined performance for MHT and MHP.

To view CAHPS and HEDIS Measures from the EQRO report, visit: https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/WV%202021%20ATR_FINAL%20508.pdf

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 CCC	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 75 th percentile.		◆◆
MCO result is equal to or exceeds the NCQA Quality Compass 75 th percentile.		◆◆◆

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.

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

The Managed Care Report to the Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA) is required by West Virginia Code Section 9-5-27 and aims to present key program metrics and evaluate the transition to managed care. BMS filed an initial report with LOCHHRA and the FCO in July 2021, with the final report due by July 1, 2023.

View the full report by visiting

https://dhhr.wv.gov/bms/Members/Managed%20Care/MHP/Documents/MHP_Legislative%20Report%20%20c2%a79-5-27_%20FINAL%20%281%29.pdf

BMS Archived Managed Care Reports

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

To view enrollment figures, quality reports, legislative reports, and annual reports, visit: <https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Pages/default.aspx>

Foster Care Ombudsman (FCO) Reporting

The FCO published an initial report for the MHP program focusing primarily on unit development and initial impressions. Sequential reports, provided on a quarterly basis, aggregate to annual reports in conformance with applicable legislation.

To view the First Report of the FCO and Quarterly Reports, visit: <https://www.wvdhhr.org/oig/fco.html>

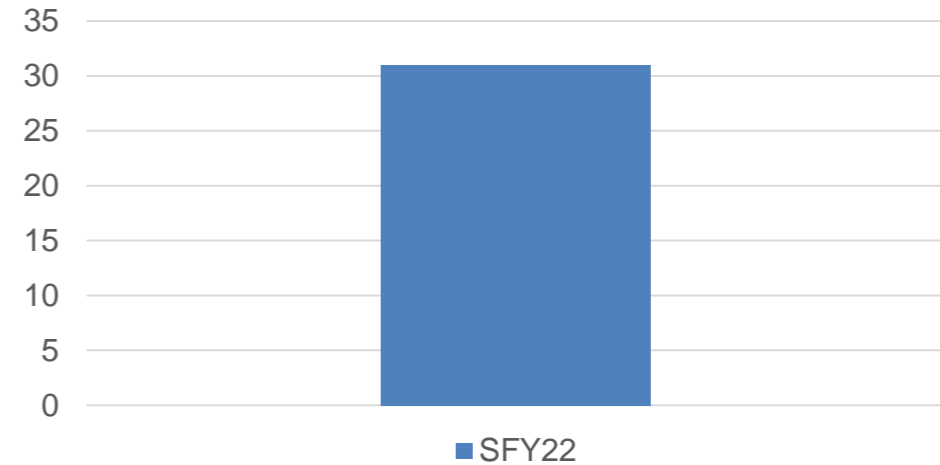
Program integrity efforts act as a gatekeeper to safeguard the Medicaid program. Multiple anti-fraud systems work together to ensure Medicaid services are administered correctly and public funds are safeguarded from fraud and misuse.

Throughout SFY 2022, BMS observed the following program integrity activities of ABHWV specific to MHP:

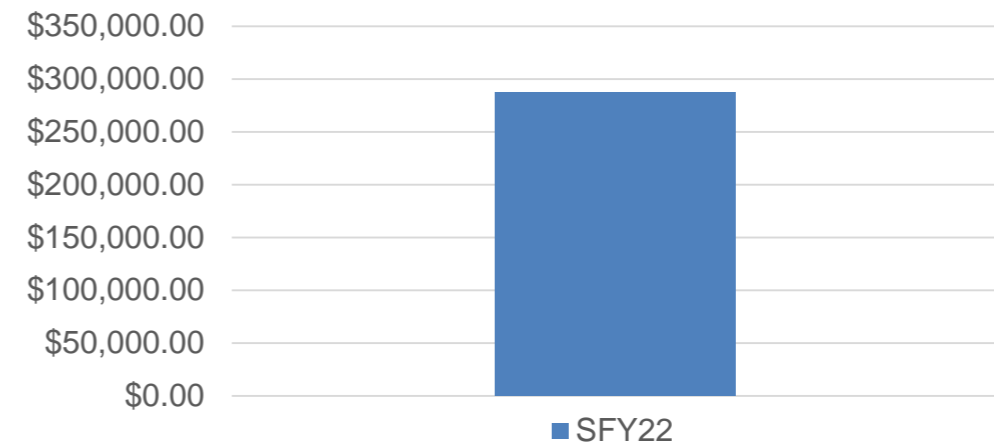
- 31 new program integrity audits.
- \$287,198.11 in overpayment recoveries.

These activities demonstrate program integrity oversight of both the MCO and their network providers. 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



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-Jurisdi/uns-k-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/MHP/Documents/MHP_Legislative%20Report%20%20c%20a79-5-27_%20FINAL%20%281%29.pdf
- <https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Pages/default.aspx>
- <https://www.wvdhhr.org/oig/fco.html>

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>

West Virginia Office of Inspector General FCO

<https://www.wvdhhr.org/oig/fco.html>

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>

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