MOUNTAIN HEALTH PROMISE

Reporting Required by W.Va. Code §9-5-27(g)

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

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Executive Summary

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) administers Mountain Health Promise (MHP), West Virginia's specialized managed care program for children and youth in foster care or the adoption assistance program. MHP is a full-risk Medicaid managed care program that provides physical, dental, behavioral health, and socially necessary services for approximately 30,000 children and youth across the state.[1] Per W. Va. Code §9-5-27, MHP seeks to:

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

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

This report is required by W. Va. Code §9-5-27(g) and aims to present key program metrics and evaluate the transition to Medicaid managed care. BMS filed an initial report with the Legislative Oversight Commission on Health and Human Resources Accountability and the FCO in July 2021, and a second report in July 2022. This is the third and final report.

Key Program Metrics

This report includes the following data metrics for March 1, 2022, to February 28, 2023:

- Number of MHP claims submitted, approved, denied, and appealed;
- Resolution of appealed claims;
- Average time of an appeal;
- Average length of stay (ALOS) in a child residential care center; and
- Health outcomes.

Evaluation of Program Transition to Managed Care

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

[1] Represents average monthly enrollment for March 2022 through February 2023. Source: West Virginia Medicaid Managed Care and Fee for Service Monthly Reports.

independent assessment indicates that the quality of care that members receive exceed Centers for Medicare & Medicaid Services (CMS) requirements in some conditions. The program is also on track to be cost effective, which will be clearer by the next independent assessment performed during the second waiver period."[2]

Mountain Health Promise Claims

Between March 1, 2022, and February 28, 2023, ABHWV received 664,117 MHP claims. *Table 1* below illustrates the total number of claims submitted, total number of claims approved or paid, and the total number of claims denied for the period. The number of claims submitted reflects adjusted claims and excludes voided or reversed transactions. The number of claims denied includes determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

Table 1. Total Number of Claims Submitted, Approved, and Denied

Total Number of Claims Submitted, Approved, and Denied *by Month for March 2022 through February 2023**			
Date	**Number of Claims Submitted[3]**	**Number of Claims Approved/Paid[4]**	**Number of Claims Denied[4]**
March 2022	57,504	51,722	4,496
April 2022	49,112	46,413	4,371
May 2022	50,069	52,664	5,533
June 2022	51,878	37,752	3,978
July 2022	60,241	44,863	4,121
August 2022	51,603	62,889	5,796
September 2022	52,806	43,518	3,885
October 2022	54,162	48,033	3,924
November 2022	55,258	62,284	5,313
December 2022	65,274	34,750	17,763**
January 2023	56,786	63,783	5,185
February 2023	59,424	54,337	5,226
Total	**664,117**	**603,008**	**69,591**

**Claims data reported by ABHWV as of June 7, 2023.*
***ABHWV reported a CXT/claim check error, which was denying claims for maximum visit limits in error.*

Appealed Claims

The Code of Federal Regulations (42 CFR § 438.402) explains that members may file a request for an appeal following the receipt of a notification of an adverse benefit determination made by an MCO. Individuals making decisions on the appeal must have the appropriate clinical

[2] West Virginia University Office of Health Affairs (2021). *Independent Assessment of WV's 1915(b) Waiver for the Specialized Managed Care Plan for Children and Youth*.
[3] Figures include adjusted claims and exclude reversed or voided claims.
[4] Figures represent all claims paid or denied in the month, regardless of the month the claims were submitted.

expertise and must neither have been involved in any previous level of review or decision-making, nor be a subordinate of any such individual. Per BMS contract requirements, the MCO must also provide notice of the appeal resolution and address at least 98 percent of appeals within 30 calendar days of the date the appeal is filed.

Table 2 shows the number of MHP claims appealed, the percentage of appeal resolutions wholly in favor of the member, and the appeal turnaround time or the average length of time from "Appeal Date of Receipt" to "Date of Resolution Letter" in days for the reporting period. During the reporting period, a total of 23 claims were appealed, of which, eight (34.8 percent) were resolved in favor of the members. The average appeal turnaround time in days for the reporting period was 18 calendar days.

Table 2. Total Number of Claims Appealed, Percentage of Appeal Resolutions Wholly in Favor of the Member, and Appeal Turnaround Time

Total Number of Claims Appealed, Percentage of Appeal Resolutions Wholly in Favor of the Member, and Appeal Turnaround Time *by Month for March 2022 through February 2023**			
Date	**Number of Claims Appealed**	**Percentage of Appeal Resolutions Wholly in Favor of the Member**	**Appeal Turnaround Time (in calendar days)**
March 2022	1	100%	17
April 2022	2	50%	21
May 2022	2	0%	16
June 2022	1	0%	29
July 2022	3	33%	10
August 2022	2	0%	30
September 2022	0	0%	0
October 2022	1	0%	29
November 2022	2	0%	29
December 2022	5	80%	18
January 2023	1	100%	0
February 2023	3	0%	17

**Claims data reported by ABHWV as of June 7, 2023.*

Children's Residential Care

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

One programmatic goal of the MHP program is to prioritize in-state placements for child residential care services. *Table 3* details the ALOS in days for MHP members admitted to in-state and out-of-state child residential care centers and group homes by month. Monthly ALOS is calculated as the total length of stay in days for all members discharged during the month divided by the total number of members discharged for the month. The out-of-state data

reported by ABHWV was collected from reports used by case management and utilization management within their organization. If members were reported on multiple reports, data that was the most complete and that showed the longest length of stay (earliest admission dates and latest discharge dates) for those members was used.

Table 3. Average Length of Stay (ALOS) in Child Residential Care Centers

Average Length of Stay (ALOS) in Child Residential Care Centers *by Month for March 2022 through February 2023**				
Date	In-State Facilities		Out-of-State Facilities	
	ALOS in Child Residential Care Centers	ALOS in Group Homes	ALOS in Child Residential Care Centers	ALOS in Group Homes
March 2022	246	142	324	399
April 2022	106	171	276	172
May 2022	72	157	269	266
June 2022	150	149	255	474
July 2022	258	156	257	420
August 2022	122	152	281	323
September 2022	253	154	240	275
October 2022	150	137	284	185
November 2022	275	128	218	505
December 2022	292	172	331	232
January 2023	174	137	286	0**
February 2023	109	113	277	170

**Child Residential Care Center data reported by ABHWV as of June 7, 2023.*
***Due to issues with the PATH system transition, ABHWV did not receive any out-of-state member reports for January 2023.*

Health Outcomes

BMS continually monitors MHP performance to understand the quality of care currently being delivered to members and to evaluate MCO performance over time. The most current External Quality Review Organization (EQRO)-assessed MHP health outcomes from the WV MHT & MHP 2022 EQRO Annual Technical Report were published in April 2023.

West Virginia Healthcare Effectiveness Data and Information Set (HEDIS®) Measures

ABHWV's HEDIS® measure rates reflect the ABHWV combined performance for MHT and MHP per National Committee for Quality Assurance (NCQA) reporting requirements. Please use the following link to view HEDIS® results for select 2022 (Measurement Year January through December 2021) performance measures: WV MHT & MHP 2022 EQRO Annual Technical Report.

West Virginia Performance Measures

Table 4 below highlights MHP-specific performance measures available for Measurement Year (MY) 2021 covering March 2022 through February 2023.

Table 4. Performance Measures for Measurement Year (MY) 2021

WV Performance Measures for Measurement Year (MY) 2021			
MHP	**Collection Method***	**ABHWV %**	**Benchmark[⅄] %**
Annual Dental Visit – 2-3 Years (ADV)^	A	44.10	♦♦♦
Child and Adolescent Well-Care Visits: 12-17 Years^	A	58.81	♦♦♦
Child and Adolescent Well-Care Visits: 18-21 Years^	A	28.11	♦♦
Contraceptive Care – All Women Ages 15-20 Long-Acting Reversible Contraception (LARC) Method of Contraception	A	5.08	♦♦
Contraceptive Care – All Women Ages 15-20 Most or Moderately Effective Method of Contraception	A	40.96	♦♦♦
Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 3 Days	A	5.32	♦♦♦
Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 60 Days	A	13.83	♦
Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 3 Days	A	9.57	♦♦♦
Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 60 Days	A	47.87	♦♦
Developmental Screening in the First Three Years of Life Age 1: Eligible children who had a screening on or before their 1st birthday	A	23.87	NC
Developmental Screening in the First Three Years of Life age 2: Eligible children who had a screening on or before their 2nd birthday	A	21.54	NC
Developmental Screening in the First Three Years of Life Age 3: Eligible children who had a screening on or before their 3rd birthday	A	20.49	NC
Developmental Screening in the First Three Years of Life Total: Total number of eligible children who had a screening in the 12 months on or before their 1st, 2nd, or 3rd birthday	A	21.70	♦
Immunizations for Adolescents - Combination 2^	H	32.12	♦
Out-of-State Placements in Foster Care	A	5.58	NC
Percentage of Eligible (Children) that Received Preventive Dental Services	A	53.14	♦♦♦
Screening for Depression and Follow-Up Plan - Ages 12-17 Years ***New measure***	A	1.87	NC
Sealant Receipt on Permanent First Molars - Rate 1 - At Least One Sealant ***New measure***	A	18.83	♦
Sealant Receipt on Permanent First Molars - Rate 2 - All Four Molars Sealed ***New measure***	A	11.34	NC

** The MCO's data collection is identified as administrative (A) or hybrid (H). Administrative data collection: rates are calculated using claims and other supplemental data. Hybrid data collection rates are calculated using administrative and medical record data.*

⅄ Benchmark source includes Quality of Care for Children in Medicaid: Findings from the 2020 Child Core Set Chart Pack, January 2022.

^ Core Set Benchmarks Not Available. Benchmarks retrieved from the NCQA Quality Compass 2022 (Measurement Year 2021 data) National Medicaid Average for All Lines Business.

♦♦♦ MCP rate is equal to or exceeds the CMS 2020 Child Core Set Chart Pack 75th Percentile.

♦♦ MCP rate is equal to or exceeds the CMS 2020 Child Core Set Chart Pack National Average, but does not meet the 75th percentile.

♦ MCP rate is below the CMS 2020 Child Core Set Chart Pack National Average.

NC (No Comparison): No Comparison made due to no rate or/and no benchmark available.

West Virginia Consumer Assessment of Healthcare Providers and Systems (CAHPS) Results

The CAHPS survey assesses healthcare quality by asking patients to report their experiences with care. The MHP CAHPS data is available for children with chronic conditions (CCC). The data presented in *Table 5* reflects survey measures and results for CY 2022. The table compares the ABHWV MHP results to the NCQA Quality Compass Medicaid health plan benchmarks.

Table 5. CY 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Children with Chronic Conditions (CCC) Population Survey Results

CY 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for CCC Population Survey Results		
Child CAHPS Survey Measures	**MHP ABHWV**	**Comparison to Benchmarks**
Getting Needed Information (% Always or Usually)	N/A	NC
Access to Prescription Medicines (% Always or Usually)	66.89	NC
Coordination of Care for CCC (% Yes)	78.25	NC
Personal Doctor Who Knows Child (% Yes)	93.55	NC
Access to Specialized Services (% Always or Usually)	N/A	NC
Rating of Health Plan (9+10)	70.06	NC

NC (No Comparison): No Comparison made due to no rate and/or no benchmark available.
N/A (Not Applicable): The organization followed the specifications, but the denominator was too small (<100) to report a valid date.

MHP Performance Improvement Projects (PIPs)

Table 6 highlights the performance improvement projects (PIPs) for MHP for two state-mandated PIPS and one selected by ABHWV. *Table 7* highlights the annual dental visits PIP measure results. *Table 8* highlights the care for adolescents PIP measure results. *Table 9* highlights the out-of-state placement for children in foster care PIP measure results.

Table 6. MHP Performance Improvement Projects (PIPs)

MHP Performance Improvement Projects (PIPs)			
2022 PIPs	**State Mandated**	**State Mandated**	**ABHWV Selected**
Topic	Annual Dental Visits	Care for Adolescents	Reducing Out-of-State Placements for Children in Foster Care
Aim	Will implementation of collaborative member, provider, and MCO interventions improve annual dental visit rates among children ages 2-3 and preventative dental services rates among children 1-20 enrolled in the ABHWV MHP program by the end of MY 2023?	Will the implementation of member, provider, and MCO interventions increase the rates of adolescent care, including well visits and immunizations received amongst members ages 9-21 enrolled with ABHWV MHP by the end of MY 2023?	Will implementation of member, provider, and MCO interventions decrease the rate of out-of-state placement for MHP members by the end of MY 2022?

MHP Performance Improvement Projects (PIPs)			
2022 PIPs	**State Mandated**	**State Mandated**	**ABHWV Selected**
Performance Measure(PM), Measure Steward, and Population	**PM 1:** Annual Dental Visits for 2-3 Year Olds **Measure Steward:** NCQA **Population:** Children 2-3 years of age **PM 2:** Percentage of Eligibles that Received Preventative Dental Services **Measure Steward:** CMS **Population:** Children, adolescents, and adults 1-20 years of age	**PM 1:** Immunizations for Adolescents (Combination 2) **Measure Steward:** NCQA **Population:** Adolescents 13 years of age **PM 2 and 3:** Child and Adolescent Well-Care Visits – 12-17 Year Olds and 18-21 Year Olds **Measure Steward:** NCQA **Population:** Adolescents and adults 12-21 years of age	**PM 1:** Reducing Out-of-State Placements for Children in Foster Care **Measure Steward:** Homegrown measure **Population:** Child and adolescent members in foster care

Table 7. MHP Annual Dental Visit Performance Improvement Project (PIP) Measure Results

MHP Annual Dental Visit Performance Improvement Project (PIP) Measure Results				
Performance Measure	**Baseline Year MY 2021**	**Last Measurement Year**	**Improvement**	**Statistically Significant Improvement**
Annual Dental Visits for 2-3 Year Olds	44.10%^	N/A	N/A	N/A
Percentage of Eligibles that Received Preventive Dental Services	53.14%^	N/A	N/A	N/A

^ *Performance was likely influenced by the COVID-19 public health emergency.*

Table 8. MHP Care for Adolescents Performance Improvement Project (PIP) Measure Results

MHP Care for Adolescents Performance Improvement Project (PIP) Measure Results				
Performance Measure	**Baseline Year MY 2021**	**Last Measurement Year**	**Improvement**	**Statistically Significant Improvement**
Immunizations for Adolescents - Combination 2	25.12%^	N/A	N/A	N/A
Child and Adolescent Well-Care Visits – 12-17 Year Olds	58.81%^	N/A	N/A	N/A
Child and Adolescent Well-Care Visits – 18-21 Year Olds	28.11%^	N/A	N/A	N/A

^*Performance was likely influenced by the COVID-19 public health emergency.*

Table 9. MHP Reducing Out-of-State Placement for Children in Foster Care Performance Improvement Project (PIP) Measure Results

MHP Reducing Out-of-State Placement for Children in Foster Care Performance Improvement Project (PIP) Measure Results				
Performance Measure	**Baseline Year MY 2020**	**Last Measurement Year MY 2021**	**Improvement**	**Statistically Significant Improvement**
Out-of-State Placement for Children in Foster Care (lower rate is better)	5.98%^	5.58%^	Yes	No

^Performance was likely influenced by the COVID-19 public health emergency.