

Managed Care Program Annual Report (MCPAR) for West Virginia: Mountain Heath Promise (MHP)

Due date	Last edited	Edited by	Status
12/27/2025	12/10/2025	Sydney Brown	Submitted









Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Selected
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If “No”, please complete the following questions under each plan.	Submitted on 10/24/2025

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	West Virginia
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Susan Deel
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	susan.h.deel@wv.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Sydney Brown
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	sydneybrown@mslc.com
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	12/10/2025



Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	07/01/2024
A5b	Reporting period end date Auto-populated from report dashboard.	06/30/2025
A6	Program name Auto-populated from report dashboard.	Mountain Heath Promise (MHP)



Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	Aetna Better Health of West Virginia

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Maximus

Add In Lieu of Services and Settings (A.9)



 Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** [Guidance on In Lieu of Services on Medicaid.gov](#).

Indicator	Response
ILOS name	N/A

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	521,689
BI.2	Statewide Medicaid managed care enrollment Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	458,600









Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	Data validation entity Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff EQRO Other third-party vendor Other, specify – Gainwell Technologies (Fiscal Agent), Milliman (Actuary), Myers and Stauffer (EDV)



Topic X: Program Integrity

Number	Indicator	Response
BX.1	Payment risks between the state and plans Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	The state has worked closely with MCO SIUs to drive improve program oversight and provider compliance. As part of this effort, the agency provides feedback to plans regarding services areas in which greater oversight will be most beneficial based on observations, trends and agency priorities. During SFY 2025, the state identified dental, durable medical equipment, and behavioral health services as an area of focus and has worked with plans to improve their policies and processes based on recent dental audit experiences. The State has continued to work with MCOs to improve oversight of institutional provider credit balances and credible allegations of fraud and increase prepayment reviews of providers as a tool for addressing persistent non-compliance.
BX.2	Contract standard for overpayments Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State requires the return of overpayments
BX.3	Location of contract provision stating overpayment standard Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 9.3 Treatment of Overypayments, in the MHP contract.
BX.4	Description of overpayment contract standard Briefly describe the overpayment standard selected in indicator B.X.2.	Section 9.3 - Treatment of Overypayments The retention of overpayments is dependent upon the circumstances under which such overpayments are identified and investigated. If the MCO does not identify and take action to recover provider overpayments in a timely manner, the Department reserves the right to identify, recover, and retain said overpayments. The Department will afford the MCO a reasonable grace period, as determined by the Department, to identify and recover overpayments from MCO providers before the Department will seek to recover and retain said overpayments.



BX.5	State overpayment reporting monitoring Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	Section 9.3.1 Department's Right to Collect from MCO The Department will send notice to the MCO with all information upon which the overpayment determination was based, along with a demand for payment. The MCO will enter into a payment agreement within thirty (30) calendar days of receiving notice, and effectuate payment within ninety (90) calendar days of notification. Failure to adhere to this process will result in liquidated damages as described in Appendix F. In the event that the MCO is invoiced for the overpayment by the Department, and the MCO recovers the overpayment from the provider, the provider's sole remedy is under the provisions of the provider's contract with the MCO. For provider appeals arising from actions taken pursuant to this section, the MCO must communicate the result of those appeals to the Department within sixty (60) calendar days of the final decision.
BX.6	Changes in beneficiary circumstances Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	Section 6.10.3 - Enrollee Change in Circumstance Reporting The MCO or its subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the state and the MCO, is required to implement and maintain procedures for notification to the state within five (5) business days of receiving information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including: 1. Changes in the enrollee's residence; and 2. The death of the enrollee.
BX.7a	Changes in provider circumstances: Monitoring plans Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	Changes in provider circumstances: Metrics Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	Changes in provider circumstances: Describe	Section 7 - QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)



metric Describe the metric or indicator that the state uses.	PROGRAM The MCO must develop and implement written policies for an ongoing QAPI program for the services it furnishes to enrollees. The QAPI must include several distinct, but interrelated comprehensive strategies and must be designed to achieve, through ongoing measurements and intervention, significant improvement in clinical and nonclinical areas of care that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Such improvements must be sustained over time. Section 9.1.4 Fraud, Waste, and Abuse Reports The MCO must submit to the Department by the fifteenth (15th) day of each month the Suspension and Adverse Enrollment Action report for all in-network suspensions, terminations for cause, and provider credentialing denials and non-renewals for cause during the prior calendar month, as noted in Article III, Section 3.1.4 and Appendix D. See also Article III, Section 9.2, and Credible Allegation of Fraud. The MCO will notify the Department of all incidents of suspected FWA even if it is also referred to an entity other than the Department such as the appropriate licensing and/or disciplinary bodies or other appropriate authorities.
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BX.8a	Federal database checks: Excluded person or entities During the state’s federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Yes
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BX.8b	Federal database checks: Summarize instances of exclusion Summarize the instances and whether the entity was notified as required in 438.602(d). Report actions taken, such as plan-level sanctions and corrective actions.	The state found 169 providers excluded (based on November 2025 MMIS Exclusion report). Reasons for exclusion/termination include, but are not limited to, OIG, license revoked by WV BOM, license voluntarily surrendered to WV BOM, terminated by another State Medicaid agency, violation of WV Medicaid policy, and criminal conviction.
BX.9a	Website posting of 5 percent or more ownership control Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	Periodic audits If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	Quarterly reports are sent to BMS and saved on their internal systems EQRO. https://bms.wv.gov/media/24916/download?inline



Topic XIII. Prior Authorization

⚠ Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics



Number	Indicator	Response
C11.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	STATE FISCAL YEAR 2025 MODEL PURCHASE OF SERVICE PROVIDER AGREEMENT FOR MOUNTAIN HEALTH PROMISE BETWEEN STATE OF WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES BUREAU FOR MEDICAL SERVICES AND Aetna Better Health of West Virginia
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2024
C11.2	Contract URL Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://bms.wv.gov/media/25236/download?inline
C11.3	Program type What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C11.4a	Special program benefits Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental
C11.4b	Variation in special benefits What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	For medical, behavioral, and dental services, the MCO will refer to the FFS Medicaid provider manuals available on the WV DoHS website for an explanation of service limitations. The MCO must promptly provide or arrange to make available for enrollees all Medically Necessary services listed below and assume financial responsibility for the provision of these services. Please note that these charts, which list the definitions of services provided under the FFS Medicaid program, are provided as a



reference for the MCO. The MCO is responsible for determining whether services are Medically Necessary and whether the MCO will require prior approval for services. Benefit packages differ depending on whether the beneficiary is covered under MHT, WVCHIP or FFS programs. WVCHIP enrollees receive the same benefits as comparable MHT Medicaid populations. For further information regarding the variations in special benefits please refer to the limitation on services sections discussed in Appendix A of the contract.

C11.5	Program enrollment Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	27,445
C11.6	Changes to enrollment or benefits Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.	Population enrolled in WV Medicaid Mountain Health Promise program has decreased steadily throughout SFY2025.

Topic III: Encounter Data Report



Number	Indicator	Response
C1III.1	Uses of encounter data For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	Criteria/measures to evaluate MCP performance What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	Encounter data performance criteria contract language Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Section 6.10.5.1 - Encounter Data Submission Section 6.10.5.4 - Errors in Submitted Encounter Data Contract Remedies and Disputes - Section 6.1 - MCO Performance - Section 6.2 - Corrective Action Plan (CAP) - Section 6.4 - Failure to Meet Contract Requirements
C1III.4	Financial penalties contract language Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Section 6.4 - Failure to Meet Contract Requirements The Department is entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or Liquidated Damages resulting from the MCO's non-performance under this Contract. [...] The Liquidated Damages prescribed in this Contract are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the Department's projected financial loss and damage resulting from the



MCO's non-performance. Accordingly, in the event the MCO fails to perform in accordance with the Contract, the Department may assess Liquidated Damages as provided in this section and in Appendix F of this Contract. Monetary penalties imposed under this Contract will not exceed the amounts established under 42 CFR §438.704. Section 6.10.5.3 Data Accuracy and Completeness Monitoring Program The MCO must have a data accuracy and completeness monitoring program in place that:

- Demonstrates that all claims and encounters submitted to the MCO by health care providers, including Subcontractors, are submitted accurately and timely as encounters to the Department;
- Evaluates health care provider and Subcontractor compliance with contractual reporting requirements; and
- Demonstrates that the MCO has the processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with all encounter reporting requirements outlined by BMS and CMS, including data elements required for HIPAA. The MCO must submit an annual Data Accuracy and Completeness Plan to the Department for review and approval by October 1st for the current fiscal year. This Plan must include the three (3) elements listed above. Along with this submission, the MCO must submit documentation of its data file layout.



C1III.5 Incentives for encounter data quality

N/A

Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.

C1III.6 Barriers to collecting/validating encounter data

The State recognized the need to provide the managed care health plans with encounter processing details, in addition to existing rejected encounter reporting, to aid in the validation of their encounter data. During the reporting period, the MMIS vendor began providing 835 response files to the health plans. As a result, the State and MMIS vendor are holding bi-weekly meetings with the health plans to address any identified encounter processing or submission issues.

Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as

your response. "N/A" is not an acceptable response.

Topic IV. Appeals, State Fair Hearings & Grievances









Number	Indicator	Response
C1IV.1	State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for “critical incidents” within the managed care program? Respond with “N/A” if the managed care program does not cover LTSS.	Critical Incident – Critical incidents are serious in nature and pose immediate risk to the health, safety, or welfare of the member or others. These incidents require in-depth investigation, an expedited timeline, and possibly additional resources.
C1IV.2	State definition of “timely” resolution for standard appeals Provide the state’s definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	4.8.1.3 Grievance and Appeal Procedures: Appeal Timeframes The MCO must address timeframes specific to enrollee appeals in the grievance and appeal procedures including, but not limited to, the following: 1. The time limit for the enrollee or his representative to file an appeal is sixty (60) calendar days from the date on the notice of adverse benefit determination; 2. The MCO must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date); 3. The MCO must process and provide notice to affected parties regarding the appeal in a reasonable length of time not to exceed thirty (30) calendar days from the day the MCO receives the appeal, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee; 4. Standard resolution and notice of appeals must occur with the timeframes established by the department and may be extended up to fourteen (14) calendar days upon the request of the enrollee or if the MCO shows that additional information is necessary and that the delay is in the interest of the enrollee;
C1IV.3	State definition of “timely” resolution for expedited appeals Provide the state’s definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the	4.8.2.2 Enrollee Expedited Appeals: Resolution Timeframes The MCO must address timeframes specific to resolution of enrollee expedited appeals in its process including, but not limited to, the following: 1. If a request for an expedited appeal is denied, the MCO must transfer the appeal to the standard resolution timeframe and make reasonable effort, as defined by the Department, to provide prompt oral notice to the enrollee, his or her representative, or provider, followed up with



MCO, PIHP or PAHP receives the appeal.

written notice within two (2) calendar days, and resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires; 2. Resolution and notice for an expedited appeal must occur within the shorter of the following two timeframes: 1) seventy-two (72) hours after the MCO receives the appeal or 2) the timeframe specified in the West Virginia Statute 33-25A. The seventy-two (72) hour timeframe may be extended by up to fourteen (14) calendar days upon the request of the enrollee, his or her authorized representative, or provider, or if the MCO shows that additional information is required and that the delay is in the interest of the enrollee; 3. The MCO must make reasonable effort to provide oral notice of disposition of an expedited appeal; and 4. If the timeframe for resolving an expedited appeal is extended for any reason other than the request of an enrollee, his or her authorized representative, or provider, the MCO must give the enrollee, his or her authorized representative, or provider written notice of the reason for the delay within two (2) calendar days and make reasonable efforts to give the enrollee prompt oral notice of the delay.



C1IV.4

State definition of “timely” resolution for grievances

Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

4.8.1.2 Grievance and Appeal Procedures: Grievance Timeframes The MCO must address timeframes specific to enrollee grievances in the grievance and appeal procedures including, but not limited to, the following: 1. Process and provide notice to affected parties regarding the enrollee grievance in a reasonable length of time not to exceed ninety (90) calendar days from the day the MCO receives the grievance, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee; 2. Ensure that standard resolution and notice for a grievance occurs with the timeframes established by the Department and that such timeframes may be extended up to fourteen (14) calendar days upon the request of the enrollee or if the MCO shows that additional information is necessary and that the delay is in the interest of the enrollee; and 3. Ensure that if the timeframe for resolving a grievance is extended for any reason other than an enrollee request, the MCO must give the enrollee written notice, within two (2) calendar days, of the reason for the delay and inform the enrollee of the right to

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	Gaps/challenges in network adequacy What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	Current challenges are where there is no providers of a specific specialty in the county or region, no appropriate provider types are located within the time/distance standards, or no provider wishes to participate that is within the time/distance standards.
C1V.2	State response to gaps in network adequacy How does the state work with MCPs to address gaps in network adequacy?	BMS requires the MCO to identify alternate methods for members to achieve access such as telehealth and single case agreements. The MCOs are required to mitigate all areas of deficiency by identifying other providers in the county or state to meet access standards. The state will assess corrective action plans on the MCOs for non-compliance. BMS will grant exceptions to CMOs based on additional documentation from the CMO that a provider may be seen out-of-network in the event a contracted provider arrangement cannot be obtained. There is an ongoing process of evaluation of all areas of deficiency until they have been met. Full network assessments are performed every year.

Topic IX: Beneficiary Support System (BSS)



Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.aetnabetterhealth.com/westvirginia/mountain-health-promise.html
C1IX.2	BSS auxiliary aids and services How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Members can access services via the website listed above, regular mail, and phone. The enrollment broker has access to interpreter services as well as TTY.
C1IX.3	BSS LTSS program data How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A
C1IX.4	State evaluation of BSS entity performance What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	BMS meets with the enrollment broker on a monthly basis to discuss activities that have taken place in the previous month. The enrollment broker provides data on enrollment and outreach activities.



Topic X: Program Integrity

Number	Indicator	Response
C1X.3	Prohibited affiliation disclosure Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity



Number	Indicator	Response
C1XII.4	Does this program include MCOs? If “Yes”, please complete the following questions.	Yes
C1XII.5	Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system? (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	Did the State or MCOs complete the most recent parity analysis(es)?	State
C1XII.7a	Have there been any events in the reporting period that necessitated an update to the parity analysis(es)? (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	Yes
C1XII.7b	Describe the event(s) that necessitated an update to the parity analysis(es). Select all that apply.	Other, specify – The addition of Highmark as an MCO (both Medicaid and WVCHIP) in August 2024 , as well as the alignment of WVCHIP with Medicaid benefits.



C1XII.8	When was the last parity analysis(es) for this program completed? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	03/25/2025
C1XII.9	When was the last parity analysis(es) for this program submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	03/25/2025
C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	Yes
C1XII.10b	In the last analysis(es) conducted, describe all deficiencies identified.	Initially, Highmark did not provide an NQTL comparative analysis for practice guidelines for either Medicaid or WVCHIP for the report. These were requested and received in April and reviewed. Medicaid/WVCHIP: Two MCOs had documentation deficiencies identified in their internal mental health parity compliance plans. The MCOs were asked to update their plans and resubmit them in October 2025. After review of the resubmission, one MCO adequately addressed the insufficiencies, and the other will be asked to resubmit in November 2025.
C1XII.11a	As of the end of this reporting period, have these	No



deficiencies been resolved
for all plans?

C1XII.11b	If deficiencies have not been resolved, select all that apply.	Other, specify – Medicaid/WVCHIP: No, one MCO's internal mental health parity needs additional documentation.
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C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website?	Yes
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The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.

C1XII.12b	Provide the URL link(s). Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://bms.wv.gov/media/25196/download?inline
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Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D11.1	Plan enrollment Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	Aetna Better Health of West Virginia 28,379
D11.2	Plan share of Medicaid What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	Aetna Better Health of West Virginia 5.4%
D11.3	Plan share of any Medicaid managed care What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)	Aetna Better Health of West Virginia 6.2%
D11.4: Parent	Organization: The name of the parent entity that controls the Medicaid Managed Care Plan. If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.	Aetna Better Health of West Virginia CVS Health



Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	Medical Loss Ratio (MLR) What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	Aetna Better Health of West Virginia 85.2%
D1II.1b	Level of aggregation What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	Aetna Better Health of West Virginia Program-specific statewide
D1II.2	Population specific MLR description Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	Aetna Better Health of West Virginia N/A
D1II.3	MLR reporting period discrepancies Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	Aetna Better Health of West Virginia Yes
N/A	Enter the start date.	Aetna Better Health of West Virginia 07/01/2023



N/A

Enter the end date.

Aetna Better Health of West Virginia

06/30/2024

Topic III. Encounter Data



Number	Indicator	Response
D1III.1	Definition of timely encounter data submissions Describe the state’s standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	Aetna Better Health of West Virginia Upon Contract termination, the MCO and Subcontractors must provide DHHR with all required reports and data through the end of the Contract period as described in this Contract. This requirement includes encounter data, which must be submitted no later than ninety (90) calendar days after the end of the quarter in which the encounters occurred. The Department may request an interim encounter data submission ninety (90) calendar days after the termination of the contract.
D1III.2	Share of encounter data submissions that met state’s timely submission requirements What percent of the plan’s encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	Aetna Better Health of West Virginia 99.36%



D1III.3

Share of encounter data submissions that were HIPAA compliant

Aetna Better Health of West Virginia

97.84%

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance?
If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.



Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	Aetna Better Health of West Virginia 20
D1IV.1a	Appeals denied Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	Aetna Better Health of West Virginia N/A
D1IV.1b	Appeals resolved in partial favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	Aetna Better Health of West Virginia N/A
D1IV.1c	Appeals resolved in favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	Aetna Better Health of West Virginia N/A
D1IV.2	Active appeals Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	Aetna Better Health of West Virginia 7
D1IV.3	Appeals filed on behalf of LTSS users Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving	Aetna Better Health of West Virginia N/A



D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

Aetna Better Health of West Virginia

N/A



D1IV.5a	Standard appeals for which timely resolution was provided Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	Aetna Better Health of West Virginia 20
D1IV.5b	Expedited appeals for which timely resolution was provided Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	Aetna Better Health of West Virginia 6
D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	Aetna Better Health of West Virginia 27
D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	Aetna Better Health of West Virginia 0
D1IV.6c	Resolved appeals related to payment denial Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's	Aetna Better Health of West Virginia 0



denial, in whole or in part, of payment for a service that was already rendered.

D1IV.6d

Resolved appeals related to service timeliness

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).

Aetna Better Health of West Virginia

0

D1IV.6e

Resolved appeals related to lack of timely plan response to an appeal or grievance

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

Aetna Better Health of West Virginia

0

D1IV.6f

Resolved appeals related to plan denial of an enrollee's right to request out-of-network care

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).

Aetna Better Health of West Virginia

4

D1IV.6g

Resolved appeals related to denial of an enrollee's request to dispute financial liability

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.

Aetna Better Health of West Virginia

0



Appeals by Service

Number of appeals resolved during the reporting period related to various services.
Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.



Number	Indicator	Response
D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	Aetna Better Health of West Virginia 12
D1IV.7b	Resolved appeals related to general outpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	Aetna Better Health of West Virginia 15
D1IV.7c	Resolved appeals related to inpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	Aetna Better Health of West Virginia 9
D1IV.7d	Resolved appeals related to outpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not	Aetna Better Health of West Virginia 2



cover outpatient behavioral health services, enter “N/A”.

D1IV.7e	Resolved appeals related to covered outpatient prescription drugs Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	Aetna Better Health of West Virginia 0
D1IV.7f	Resolved appeals related to skilled nursing facility (SNF) services Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	Aetna Better Health of West Virginia N/A
D1IV.7g	Resolved appeals related to long-term services and supports (LTSS) Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	Aetna Better Health of West Virginia 5
D1IV.7h	Resolved appeals related to dental services Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	Aetna Better Health of West Virginia 0
D1IV.7i	Resolved appeals related to non-emergency medical transportation (NEMT)	Aetna Better Health of West Virginia 0



Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

D1IV.7k: Resolved appeals related to durable medical equipment (DME) & supplies

Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia
N/A

D1IV.7l: Resolved appeals related to home health / hospice

Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia
N/A

D1IV.7m: Resolved appeals related to emergency services / emergency department

Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia
N/A

D1IV.7n: Resolved appeals related to therapies

Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia
N/A

D1IV.7o Resolved appeals related to other service types

Aetna Better Health of West Virginia



Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter "N/A".

N/A

State Fair Hearings









Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	Aetna Better Health of West Virginia N/A
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	Aetna Better Health of West Virginia N/A
D1IV.8c	State Fair Hearings resulting in an adverse decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	Aetna Better Health of West Virginia N/A
D1IV.8d	State Fair Hearings retracted prior to reaching a decision Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	Aetna Better Health of West Virginia N/A
D1IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	Aetna Better Health of West Virginia N/A
D1IV.9b	External Medical Reviews resulting in an adverse decision for the enrollee	Aetna Better Health of West Virginia N/A



If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Grievances Overview



Number	Indicator	Response
D1IV.10	Grievances resolved Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.	Aetna Better Health of West Virginia 122
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	Aetna Better Health of West Virginia 6
D1IV.12	Grievances filed on behalf of LTSS users Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	Aetna Better Health of West Virginia N/A
D1IV.13	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter “N/A” in this field. Additionally, if the state already submitted this	Aetna Better Health of West Virginia N/A



data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter “N/A” in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

D1IV.14	Number of grievances for which timely resolution was provided Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	Aetna Better Health of West Virginia 122
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Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.



Number	Indicator	Response
D1IV.15a	Resolved grievances related to general inpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.	Aetna Better Health of West Virginia 2
D1IV.15b	Resolved grievances related to general outpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	Aetna Better Health of West Virginia 117
D1IV.15c	Resolved grievances related to inpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	Aetna Better Health of West Virginia 5
D1IV.15d	Resolved grievances related to outpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or	Aetna Better Health of West Virginia 4



substance use services. If the managed care plan does not cover this type of service, enter "N/A".

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia

0

D1IV.15f

Resolved grievances related to skilled nursing facility (SNF) services

Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia

N/A

D1IV.15g

Resolved grievances related to long-term services and supports (LTSS)

Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia

N/A

D1IV.15h

Resolved grievances related to dental services

Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia

3

D1IV.15i

Resolved grievances related to non-emergency medical transportation (NEMT)

Enter the total number of grievances resolved by the plan

Aetna Better Health of West Virginia

0



during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".

D1IV.15k

Resolved grievances related to durable medical equipment (DME) & supplies

Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia

N/A

D1IV.15l

Resolved grievances related to home health / hospice

Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia

N/A

D1IV.15m

Resolved grievances related to emergency services / emergency department

Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia

N/A

D1IV.15n

Resolved grievances related to therapies

Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".

Aetna Better Health of West Virginia

N/A



D1IV.15o

Resolved grievances related to other service types

Aetna Better Health of West Virginia

N/A

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter "N/A".

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.



Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	Aetna Better Health of West Virginia 3
D1IV.16b	Resolved grievances related to plan or provider care management/case management Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	Aetna Better Health of West Virginia 1
D1IV.16c	Resolved grievances related to network adequacy or access to care/services from plan or provider Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	Aetna Better Health of West Virginia 1
D1IV.16d	Resolved grievances related to quality of care Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	Aetna Better Health of West Virginia 10
D1IV.16e	Resolved grievances related to plan communications Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan	Aetna Better Health of West Virginia 1



communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

D1IV.16f

Resolved grievances related to payment or billing issues

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

Aetna Better Health of West Virginia

106

D1IV.16g

Resolved grievances related to suspected fraud

Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

Aetna Better Health of West Virginia

0

D1IV.16h

Resolved grievances related to abuse, neglect or exploitation

Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

Aetna Better Health of West Virginia

0

D1IV.16i

Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)

Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

Aetna Better Health of West Virginia

0

D1IV.16j

Resolved grievances related to plan denial of expedited appeal

Enter the total number of grievances resolved by the plan during the

Aetna Better Health of West Virginia

0



reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.

D1IV.16k	Resolved grievances filed for other reasons	Aetna Better Health of West Virginia
	Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	0









Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.



D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use - 30-Day Follow-Up: Ages 13 to 17 1 / 41

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
Yes

D2.VII.8 Measure Description
Ages 13 to 17

Measure results

Aetna Better Health of West Virginia
38.46



D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use - 7-Day Follow-Up: Ages 13 to 17 2 / 41

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
Yes

D2.VII.8 Measure Description
Ages 13 to 17

Measure results

Aetna Better Health of West Virginia
17.95



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents - Combination 3 / 41 2

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

32.6



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up: Ages 6 to 17 4 / 41

D2.VII.2 Measure Domain

Behavioral health care

**D2.VII.3 National Quality
Forum (NQF) number**

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

Ages 6 to 17

Measure results

Aetna Better Health of West Virginia

80.7



D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (12-17 Yrs) 5 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

12-17 Years

Measure results

Aetna Better Health of West Virginia

63.45



D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (18-21 Yrs) 6 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

18-21 Years

Measure results

Aetna Better Health of West Virginia

32.14



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents - HPV

7 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

HPV

Measure results

Aetna Better Health of West Virginia

32.85



Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (15-30 Months) 8 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1392

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

15-30 Months

Measure results

Aetna Better Health of West Virginia

81.7



D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (0-15 Months) 9 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1392

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

0-15 Months

Measure results

Aetna Better Health of West Virginia

49.6



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile: Total Ages 3 to 17 10 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Total Ages 3 to 17

Measure results

Aetna Better Health of West Virginia

95.38



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: Total Ages 3 to 17

11 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Total Ages 3 to 17

Measure results

Aetna Better Health of West Virginia

83.45



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: Total Ages 3 to 17

12 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Total Ages 3 to 17

Measure results

Aetna Better Health of West Virginia

82.48



D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits: Ages 3 to 11 13 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Ages 3 to 11

Measure results

Aetna Better Health of West Virginia

71.16



D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits: Total Ages 3 to 21 14 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Total Ages 3 to 21

Measure results

Aetna Better Health of West Virginia

63.41



D2.VII.1 Measure Name: Lead Screening in Children

15 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

68.61



D2.VII.1 Measure Name: Screening for Depression and Follow-Up Plan: 16 / 41 Ages 12-17

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0418

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Ages 12-17

Measure results

Aetna Better Health of West Virginia

2.30



D2.VII.1 Measure Name: Childhood Immunization Status - Combo 10

17 / 41

Complete

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

n/A

Measure results

Aetna Better Health of West Virginia

21.9



Complete

D2.VII.1 Measure Name: Childhood Immunization Status - Combo 3

18 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

**D2.VII.3 National Quality
Forum (NQF) number**

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting
period: Date range**

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

74.94



Complete

D2.VII.1 Measure Name: Childhood Immunization Status - Combo 7

19 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

57.91



Complete

D2.VII.1 Measure Name: Childhood Immunization Status - DTaP

20 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

80.78



Complete

D2.VII.1 Measure Name: Childhood Immunization Status - Hepatitis A 21 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

0038

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

91.24



Complete

D2.VII.1 Measure Name: Childhood Immunization Status - Hepatitis B 22 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

97.08



Complete

D2.VII.1 Measure Name: Childhood Immunization Status - HiB 23 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
Yes

D2.VII.8 Measure Description
N/A

Measure results

Aetna Better Health of West Virginia
92.70


Complete

D2.VII.1 Measure Name: Childhood Immunization Status - Influenza 24 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
Yes

D2.VII.8 Measure Description
N/A

Measure results

Aetna Better Health of West Virginia
31.63


Complete

D2.VII.1 Measure Name: Childhood Immunization Status - IPV 25 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number
0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

94.40

 Complete

D2.VII.1 Measure Name: Childhood Immunization Status - MMR

26 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

91.97

 Complete

D2.VII.1 Measure Name: Childhood Immunization Status - Pneumococcal Conjugate

27 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes



D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health of West Virginia**

78.83



Complete

D2.VII.1 Measure Name: Childhood Immunization Status - Rotavirus 28 / 41**D2.VII.2 Measure Domain**

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results**Aetna Better Health of West Virginia**

68.86



Complete

D2.VII.1 Measure Name: Childhood Immunization Status - VZV 29 / 41**D2.VII.2 Measure Domain**

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A



Measure results

Aetna Better Health of West Virginia

92.46



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up: Ages 6 to 17

30 / 41

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Ages 6 to 17

Measure results

Aetna Better Health of West Virginia

74.2



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents - Combination 1

31 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents - Meningococcal

32 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia

83.7



Complete

D2.VII.1 Measure Name: Immunizations for Adolescents - Tdap

33 / 41

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health of West Virginia



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17)

34 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

BMI percentile (12-17)

Measure results

Aetna Better Health of West Virginia

95.96



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile: Ages 3 to 11

35 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

BMI percentile (3-11)

Measure results

Aetna Better Health of West Virginia



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: Ages 12 to 17

36 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Counseling for Nutrition (12-17)

Measure results

Aetna Better Health of West Virginia

80.81



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: Ages 3 to 11

37 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Counseling for Nutrition (3-11)

Measure results



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: Ages 12 to 17

38 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Counseling for Physical Activity (12-17)

Measure results

Aetna Better Health of West Virginia

82.32



D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: Ages 3 to 11

39 / 41

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Counseling for Physical Activity (3-11)

Measure results



Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care - Postpartum Care: Under Age 21 40 / 41

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Under Age 21

Measure results

Aetna Better Health of West Virginia

91.21



Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care - Timeliness of Prenatal Care: Under Age 21 41 / 41

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Under Age 21

Measure results

Aetna Better Health of West Virginia

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.





Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 2

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Aetna Better Health of West Virginia

D3.VIII.4 Reason for intervention

A request for information issued by the Medicaid Fraud Control Unit (MFCU) titled "Pacific" was issued to Aetna Better Health of West Virginia (ABHWV) on October 18, 2024, with a due date of November 1, 2024. An extended due date was requested by ABHWV and granted through November 22, 2024. ABHWV submitted their response to this request on December 5, 2024, six (6) business days beyond the extended deadline. The state department establishes timeliness standards "for all BMS Program Integrity and MFCU requests for data, records, or other information." This section requires that Mountain Health Trust service providers respond, "within fourteen (14) calendar days or within the timeframe designated in the request." Failure to comply with this provision of the agreement constitutes a program non-performance under standard number one as detailed in appendix F of the Mountain Health Trust Service Provider Agreement which addresses "failure to submit required reports, information requests, documentation, ad hoc reports, data certification forms, overpayment remittances, or any other item required within the timeframe provided by this contract." Program Non-Performance under this standard carries liquidated damages in the amount of "\$250 per business day per each item that is overdue until the satisfactory submission of the required report, documentation, ad hoc report, data certification form, or data required to meet any State or federal reporting requirements."

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

\$1,500

D3.VIII.7 Date assessed

01/08/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No



D3.VIII.1 Intervention type: Liquidated damages

2 / 2

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

Aetna Better Health of West Virginia

D3.VIII.4 Reason for intervention

The Aetna Better Health of West Virginia (ABHWV) Special Investigations Unit (SIU) received an email from the Bureau for Medical Services (BMS/the agency) Office of Program Integrity (OPI) which requested the submission of fraud referrals for a list of four (4) provider cases. These referrals were required based on reviews of audit activity conducted by the ABHWV SIU which resulted in the identification of potentially fraudulent activity. ABHWV engaged directly with a provider for which a fraud referral was required and reached an agreement to resolve overpayments which potentially resulted from fraudulent activity. These actions taken by ABHWV constitute a failure to adhere to prohibitions and requirements related to program integrity and the recovery of overpayments which resulted in material harm to the ability of the OAG MFCU to investigate and prosecute the potentially fraudulent activity identified. Section 9.1.5 of the Mountain Health Trust (MHT) Service Provider Agreement states: "...If OPI accepts the case for State investigation, the MCO may not engage in investigation efforts other than coordination efforts with the State. The OPI must supply a notice to the MCO notifying it of the case acceptance status no later than the tenth (10th) business day after the MCO notifies the OPI of suspected fraud or abuse.

Sanction details**D3.VIII.5 Instances of non-compliance**

2

D3.VIII.6 Sanction amount

\$250,310.58

D3.VIII.7 Date assessed

02/13/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

**Topic X. Program Integrity**

Number	Indicator	Response
D1X.1	Dedicated program integrity staff Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	Aetna Better Health of West Virginia 3
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	Aetna Better Health of West Virginia 87
D1X.4	Count of resolved program integrity investigations How many program integrity investigations were resolved by the plan during the reporting year?	Aetna Better Health of West Virginia 82
D1X.6	Referral path for program integrity referrals to the state What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	Aetna Better Health of West Virginia Makes referrals to the State Medicaid Agency (SMA) only
D1X.7	Count of program integrity referrals to the state Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	Aetna Better Health of West Virginia 7
D1X.9a:	Plan overpayment reporting to the state: Start Date What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	Aetna Better Health of West Virginia 07/01/2024



D1X.9b:	Plan overpayment reporting to the state: End Date What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	Aetna Better Health of West Virginia 06/30/2025
D1X.9c:	Plan overpayment reporting to the state: Dollar amount From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	Aetna Better Health of West Virginia \$700,125
D1X.9d:	Plan overpayment reporting to the state: Corresponding premium revenue What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	Aetna Better Health of West Virginia \$211,403,824.90
D1X.10	Changes in beneficiary circumstances Select the frequency the plan reports changes in beneficiary circumstances to the state.	Aetna Better Health of West Virginia Weekly



Topic XI: ILOS

⚠ Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	Aetna Better Health of West Virginia No ILOSs were offered by this plan

Topic XIII. Prior Authorization

⚠ Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

⚠ Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.



Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	BSS entity type What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Maximus Enrollment Broker
EIX.2	BSS entity role What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	Maximus Enrollment Broker/Choice Counseling Beneficiary Outreach Other, specify – Beneficiary Education

Section F: Notes



Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	Notes (optional)	Not answered

