West Virginia Medicaid
Mountain Health Trust

Annual Report

State Fiscal Year 2025
(July 2024-June 2025)

September 30, 2025

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
Bureau for Medical Services

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A Message from the Commissioner

Cynthia Beane, Commissioner of the Bureau for Medical Services

I am pleased to present the West Virginia Department of Human Services (DoHS) Bureau for Medical Services (BMS) State Fiscal Year (SFY) 2025 Annual Report. This report provides an overview of BMS's accomplishments in serving our Mountain Health Trust (MHT) managed care population.

MHT is a vital program for West Virginia's population, providing Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) coverage to approximately 386,000 West Virginians. During SFY25, BMS' MHT program delivered Medicaid and WVCHIP services in new and innovative ways, emphasizing quality improvements, social determinants of health (SDOH), and targeted behavioral health interventions.

Of note, during SFY25, the MHT program:

- **Began the implementation of quality programs legislated under Senate Bill (SB) 820:** Day One Enrollment into managed care, a managed care organization (MCO) Quality Withhold program, and targeted performance measures for inpatient substance use disorder (SUD) provider care. Each of these programs provide unique strategies to improve health care quality for enrollees and promote fiscal efficiency for the MHT program.
- **Implemented Certified Community Behavioral Health Clinics (CCBHCs):** CCBHC services include a comprehensive set of outpatient community-based behavioral health services and supports for individuals across the life span that are delivered in an integrated, whole-person approach. Coordination with CCBHCs by MCOs provides an essential service to MHT members with behavioral health needs, improving the quality of care delivered to a vulnerable population.
- **Renewed the Section 1115(a) Waiver (Evolving West Virginia Medicaid's Behavioral Health Continuum of Care):** Effective January 1, 2025 through December 31, 2029, the renewal of this waiver provides expanded recovery and support services for enrollees with SUD needs. This waiver includes expanded Peer Recovery Support Specialist services, restructuring of residential SUD programs, reentry services for justice-involved individuals with SUD, and quick response teams for substance use-related emergencies. These evidence-based strategies will be instrumental in improving SUD outcomes in the state.

These accomplishments underscore BMS's commitment to improving health care quality and accessibility for West Virginians. I encourage you to review this report in its entirety to see how BMS has used MHT to provide the best quality care for West Virginians throughout SFY25.

Agency Overview

West Virginia Department of Human Services

The West Virginia Department of Human Services (DoHS) promotes a thriving and healthy West Virginia through providing access to critical health care, essential social services and benefits, and trusted information, with a special emphasis on vulnerable populations. DoHS's mission is to promote and provide health and human services to the people of West Virginia to improve their quality of life and health outcomes. DoHS comprises the following areas:

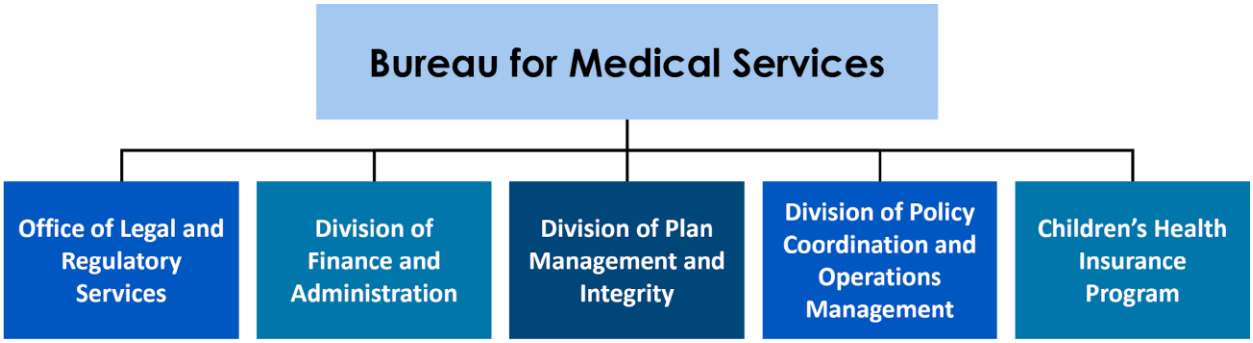
- Bureau for Social Services (BSS).
- Bureau for Medical Services (BMS).
- Bureau for Child Support Enforcement (BSCE).
- Bureau for Family Assistance (BFA).

- Bureau for Behavioral Health (BBH).
- Office of Drug Control Policy (ODCP).
- Boards and Commissions.

Bureau for Medical Services

BMS is the designated single state agency responsible for the administration of the State's Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) programs and for providing access to appropriate health care for eligible West Virginians. BMS establishes and administers overall strategic direction and priorities for the Medicaid and WVCHIP programs. BMS is organized into various divisions and sections, each of which works together to achieve the effective and efficient administration and support of the overall Medicaid and WVCHIP programs. The four BMS divisions are identified in *Figure 1*. The Division of Plan Management and Integrity encompasses the Office of Managed Care, which monitors and oversees the MHT program in partnership with the Children's Health Insurance Program (CHIP).

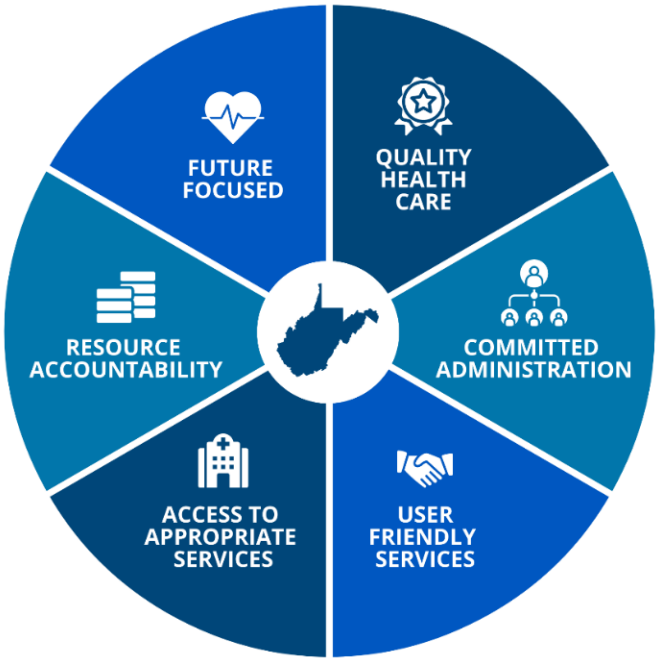
Figure 1: BMS Organizational Structure



BMS Mission

BMS is committed to administering the Medicaid and WVCHIP programs, while maintaining accountability for the use of resources in a way that ensures access to appropriate, medically necessary, and quality health care services for all members — providing these services in a user-friendly manner to providers and members alike and focusing on the future by providing preventive care programs. See *Figure 2* for a visual depiction of the West Virginia BMS mission.

Figure 2: West Virginia BMS Mission



Program Oversight

The BMS Medical Services Fund Advisory Council (MSFAC) meets quarterly to provide BMS with input on the Medicaid Services Fund, disbursements from the fund and the provision of health and medical services. The MSFAC includes providers, members, legislators, and agency staff who meet to advise BMS on a range of issues, including providing feedback on quality activities and program administration. These MSFAC meetings provide the State with a high level of oversight of program administration issues and promotes continuous improvement in all aspects of the program (e.g., enrollment, health care delivery, external monitoring, etc.).

Program Overview

What is Medicaid?

Medicaid is an important safety net in the health care system, providing publicly funded health insurance coverage to millions of low-income Americans. The program was signed into law in 1965 and authorized under Title XIX of the Social Security Act (SSA). It began as a cash assistance program for parents and children with low income and people with disabilities. Medicaid has evolved over time to cover more people and offer a broad array of health care services.

Who Does Medicaid Help?

Medicaid provides medical care to eligible U.S. citizens in their communities or in institutional settings, such as nursing homes, who otherwise may not be able to afford care. Federal law requires states to cover certain groups of individuals, such as families with low income, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI). States also have the option to cover other groups of individuals who otherwise may not be eligible under the federal standards. Medicaid provides a comprehensive set of services, including basic medical care and preventive treatment, as well as ancillary services like transportation and long-term care support. West Virginia expanded coverage to low-income adults under the Affordable Care Act Medicaid expansion option and integrated these members into the MHT delivery system.

How is Medicaid Funded?

Medicaid is funded by a federal and state government partnership that shares the cost of covering eligible individuals. The Centers for Medicare & Medicaid Services (CMS) establishes a Federal Medical Assistance Percentage (FMAP) rate each year for every state. This FMAP varies across states and provides reimbursement to states based on the average per capita income for each state relative to the national income average.

States like West Virginia with lower average incomes receive higher reimbursement rates from the federal government to support Medicaid program costs.[1] This means that the federal government carries a larger share of the financial burden of West Virginia's Medicaid program. In federal fiscal year (FFY) 2025, West Virginia's starting FMAP rate was 73.84%. This means the

[1] United States Census Bureau. West Virginia.

federal government reimbursed West Virginia approximately $0.74 of every eligible dollar spent on Medicaid. Please visit this link to learn more about FMAP.

What is WVCHIP?

West Virginia Children's Health Insurance Program (WVCHIP) is a federally funded program providing coverage to children under the age of 19 who reside in West Virginia but are not eligible for West Virginia Medicaid, as well as uninsured pregnant women over the age of 19 within income guidelines. Additional eligibility criteria include:

- Income and family size fall within qualifying Income Guidelines.
- Public Employees' children who meet the WVCHIP Eligibility Requirements.
- Are United States citizens or qualified non-citizens (Children who are not U.S. citizens must provide verification of their status.)

WVCHIP benefits, including dental, medical, and behavioral health services, are provided through the MHT program by BMS. Similarly to Medicaid, WVCHIP receives funding through a federal and state partnership, however, WVCHIP receives an enhanced FMAP. The FMAP for WVCHIP services in SFY25 was 81.69%, meaning the federal government reimbursed West Virginia approximately $0.82 of every eligible dollar spent on WVCHIP.

Mountain Health Trust

Program Overview

The MHT program was implemented in 1996 as the State's first risk-based managed care program. MHT was established under Section 1915(b) waiver authority of the SSA of 1981.[2] Every two years, states are required to renew their 1915(b) waivers and report program monitoring results to CMS for the prior waiver period. During SFY25, BMS requested renewal of the MHT 1915(b) waiver by providing evidence and documentation of satisfactory performance and oversight. CMS provided an approval to continue operation of the MHT program for a two-year period beginning July 1, 2025 through June 20, 2027.

West Virginia has Title XXI State Plan authority to deliver health benefits through WVCHIP. WVCHIP members received benefits through the Public Employees Insurance Agency for state workers and their families until July 1, 2021, when BMS shifted service delivery for WVCHIP into managed care. Effective July 1, 2023, WVCHIP adopted the Medicaid benefit package for medical, behavioral and dental health services. On July 1, 2024, WVCHIP adopted the Medicaid pharmacy benefit, and opted to comply with Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) requirements for members.

For the MHT program, BMS contracts with four MCOs to provide services to enrollees. Those MCOs are Aetna Better Health of West Virginia (ABHWV), Highmark Health Options West Virginia (HHOWV), The Health Plan of West Virginia (THP), and Wellpoint West Virginia (WP). Visit the following MCO websites to view covered services under the MHT program:

[2] Social Security Administration. Provisions Respecting Inapplicability and Waiver of Certain Requirements of This Title, SSA of 1981, Sec. 1915. [42 U.S.C. 1396n].

- Aetna Better Health of West Virginia.
- Highmark Health Options West Virginia.
- The Health Plan.
- Wellpoint West Virginia.

HHOWV entered the MHT program in August 2024 through the Request for Application process. BMS performed a comprehensive readiness review to confirm HHOWV was adequately equipped to comply with the terms and requirements of the MHT program.

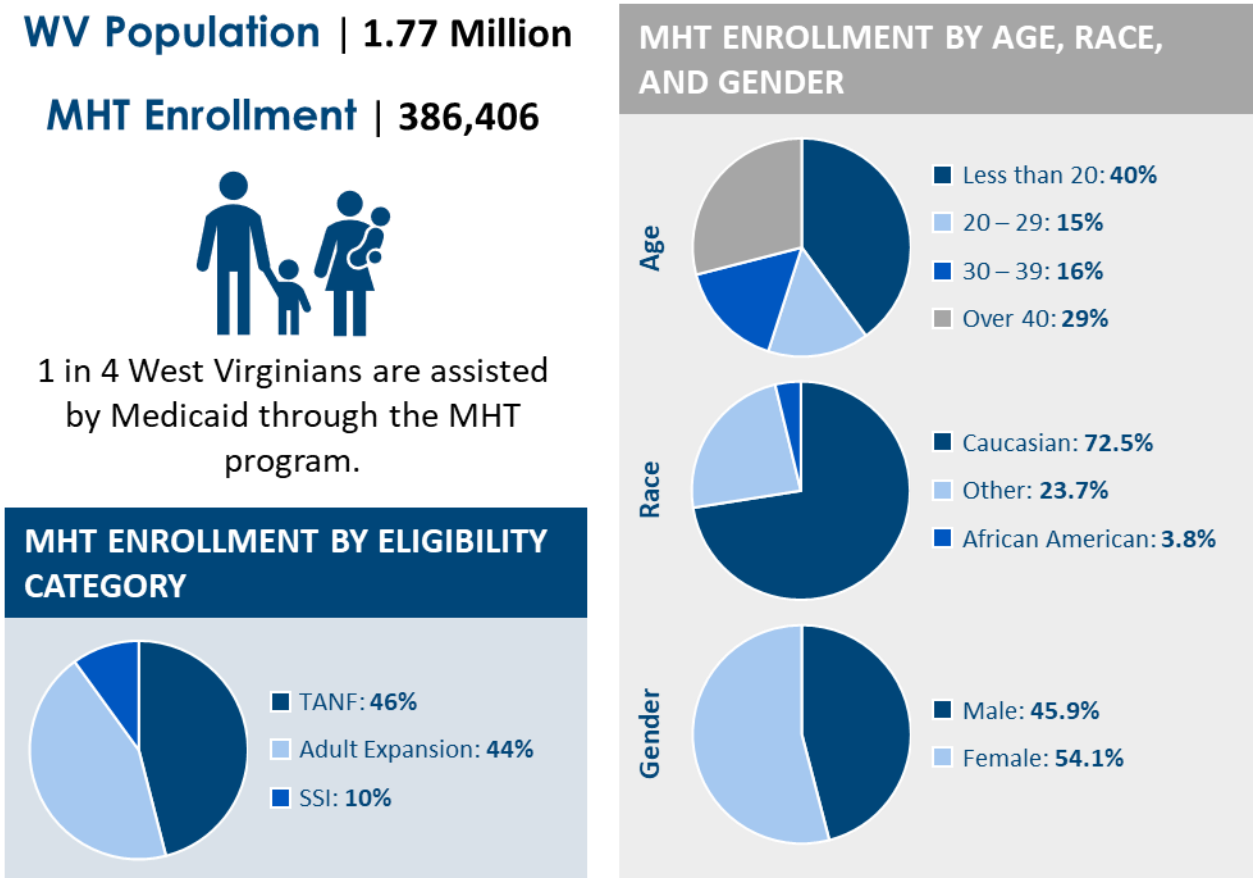
MHT Enrollment and Demographic Information

As of July 1, 2025, MHT serves approximately 386,406 members.[3] The most common eligibility categories include temporary assistance for needy families (TANF), adult expansion, and SSI income. Pregnant women and children's special health care needs represent a nominal number (less than 1%) of enrolled members. Populations of less than 1% are not represented in *Figure 3*.[4] *Figure 3* also provides a breakdown of MHT membership by age, race, and gender.

[3] West Virginia BMS MHT enrollment data through July 1, 2025, as of August 2025.

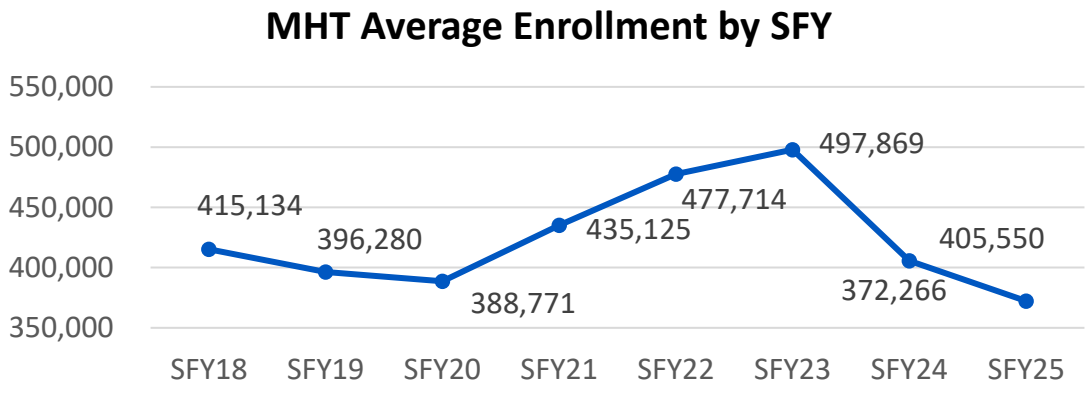
[4] West Virginia Census and MHT encounter data through July 1, 2025, as of August 2025.

Figure 3: MHT Enrollment Breakdown



The public health emergency (PHE) resulting from COVID-19 had a significant impact on Medicaid enrollment in recent years. CMS suspended Medicaid disenrollment and ensured eligible members remained covered during the PHE. This ended with the PHE expiration in May 2023. *Figure 4*[5] shows the steady increase in the number of individuals enrolled in the program from SFY20-SFY22 with declines in average enrollment in SFY23-SFY25.

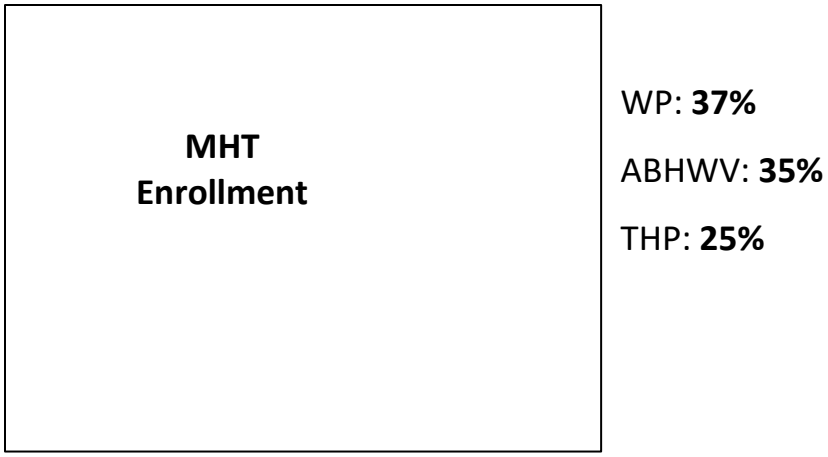
Figure 4: MHT Average Enrollment by SFY and by MCO



[5] Ibid.

Figure 5 shows the proportion of MHT enrollees in each MCO. Wellpoint has the highest proportion of enrollment, while HHOWV began receiving membership in August 2024 and has the lowest proportion of members.

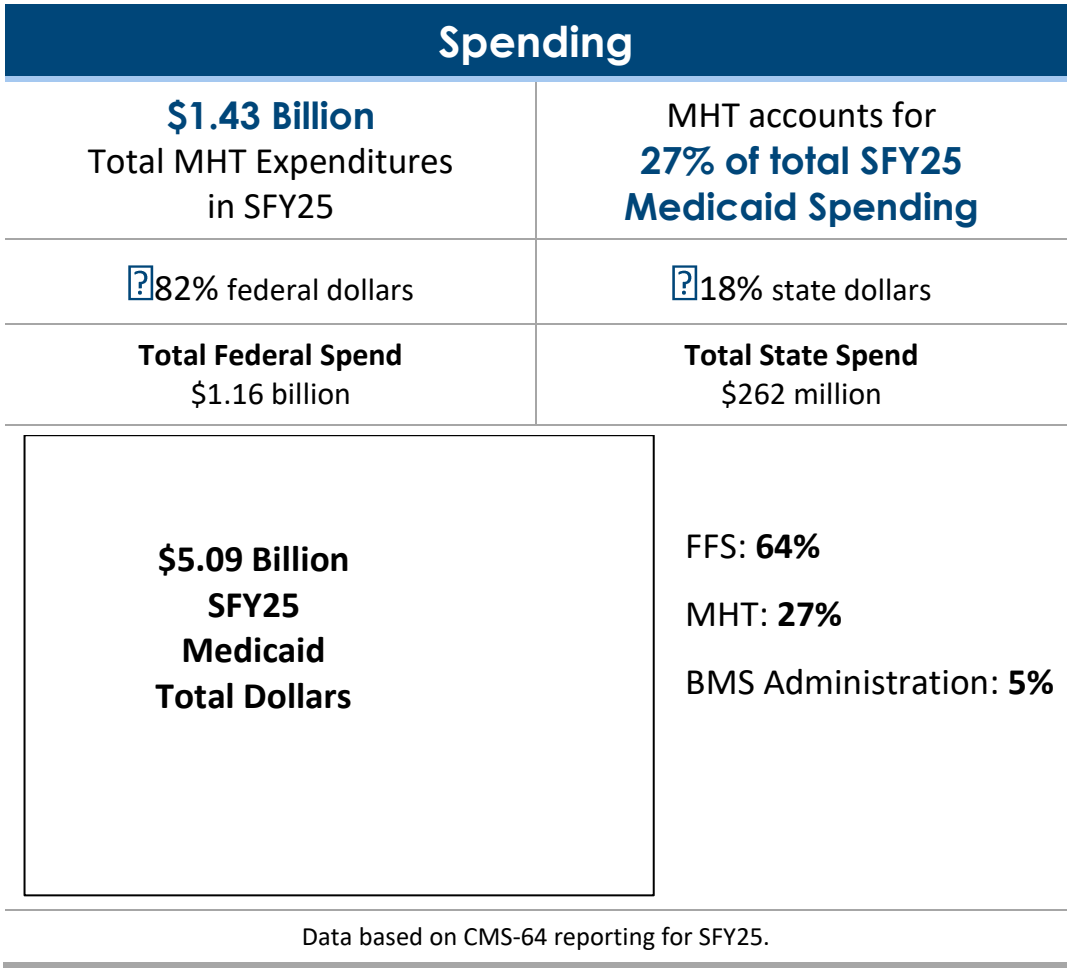
Figure 5: MHT Enrollment by MCO



Program Expenditures

The data presented in *Figure 6* reflects the total SFY25 expenditures for the Medicaid programs. The figures below present the percentage of total expenditures sourced from federal and state spend for SFY25. Medicaid members in West Virginia receive care through one of two delivery methods — Medicaid managed care and fee-for-service (FFS). The Mountain Health Promise (MHP) SFY25 expenditures represent approximately 4% of the total federal and state spend. The MHT program totals approximately 27% of total dollars spent, while 64% is attributed to FFS.

Figure 6: SFY25 Medicaid Spending



Directed Payment Programs

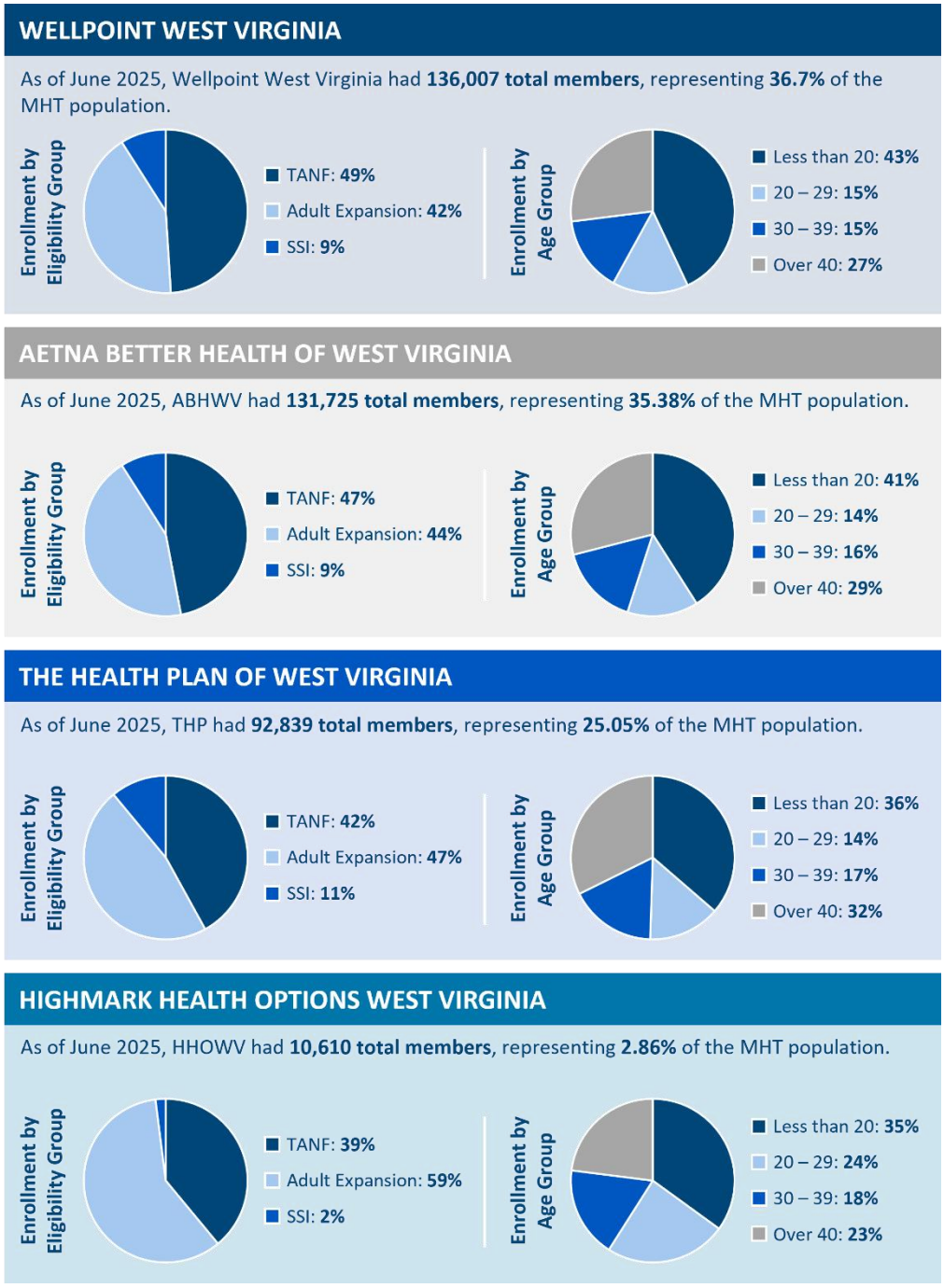
Created through the 2016 Medicaid managed care rule, directed payment programs (DPP) allow the State to require MCOs to pay providers according to certain rates or methods established or "directed" by the State. They allow the State to distribute funding and incentives to providers with the goal of improving health outcomes and enhancing health care delivery. States must submit proposed DPPs to CMS for review and approval to ensure they are within federal guidelines before implementation. These payment arrangements can include setting a minimum and maximum payment rate for specific types of health care providers, as well as value-based payment (VBP) arrangements, which seek to advance the State's Managed Care Quality Strategy goals. In SFY25, West Virginia's health care delivery system received approximately $135 million in hospital DPP and $56 million through the Senate Bill (SB) 546 (provider specialist) DPP. The MCOs received several CMS-approved supplemental payments from BMS in SFY25, including:

- $21.6 million for school-based services.
- $16.7 million for direct medical education.
- $3.2 million for the Health Insurance Premium Payment Program.
- $1.95 million for the critical access hospital settlement

MCO Profiles

MCOs are essential in the coordination of health care services and benefits while focusing on improving health outcomes for their members. The MCO profiles in *Figure 7* provide enrollment details specific to each of West Virginia's four contracted MCOs. Please note that populations of less than 1% are not represented.

Figure 7: MHT MCO Profiles



Quality Assurance

External Quality Review

Annual Technical Report

A core component of the BMS mission is to guarantee services provided for Medicaid members are not only effective but also readily available and delivered efficiently. The Annual Technical Report (ATR) published by BMS evaluates key activities including quality access to care, and timeliness of services. The ATR serves as a valuable tool for understanding the program's performance and identifying areas for improvement.

To achieve these objectives, BMS relies on its contracted external quality review organization (EQRO) vendor, Qlarant Quality Solutions (Qlarant), to conduct a comprehensive independent evaluation to assess the compliance of West Virginia's Medicaid managed care program. During the process, Qlarant examines the performance of the program, assessing its strengths and identifying any areas for improvement. The external review focuses on areas, such as service quality, service accessibility, and timeliness of care.

Want to Know More?

Click here to view the 2024 ATR.

When the EQRO completes its evaluation, BMS demonstrates its commitment to transparency and accountability by publishing the ATR. The report is a public document outlining the findings of the review and detailing how well the State has managed the Medicaid managed care program and the contracted MCOs. This report serves as a valuable tool for guiding future program development and ensuring continued high-quality health care access for West Virginia's Medicaid members.

External Quality Review Conclusions

Qlarant's evaluation found that West Virginia's MHT program continues to make strides in enhancing the quality and accessibility of health care services for members. The MCOs were fully compliant with federal and state managed care requirements, met 100% systems performance ratings, and demonstrated the ability to produce accurate encounter data.

Qlarant also noted all MCOs demonstrated their commitment to quality and quickly responded to recommendations or requests for corrective actions. Performance continues to trend in a positive direction and provides evidence of improved quality, accessibility, and timeliness.

For the MHT program, Qlarant observed that the MCOs were methodical in their approach to reach their Performance Improvement Project (PIP) and quality improvement goals. PIPs use a structured method to improve quality, helping MCOs identify barriers and apply targeted interventions. BMS required the MCOs to report on three PIPs, two State-mandated PIPs, and one MCO-selected PIP. HHOWV did not participate in any PIP activity due to their August 1, 2024 start date; however, all other MCOs initiated a new State-mandated PIP, Lead Screening in Children (LSC), and reported baseline performance. The MHT program and MCOs reported

improvement in State-mandated and self-selected PIPs. These positive developments are expected to lead to better health outcomes for the populations served.

MCO Accreditation

Accreditation

Health plans (or MCOs) earn National Committee for Quality Assurance (NCQA) accreditation through an independent review of the health plan's systems and processes, which evaluates multiple dimensions of care, service, and efficiency. An NCQA accreditation survey involves on-site and off-site evaluations conducted by a survey team of physicians and managed care experts. NCQA health plan accreditation standards are used to perform gap analysis and determine areas of improvement.

Want to Know More?

For more information on the NCQA accreditation process and detailed information on MCO ratings, visit here.

Health plan ratings differ from accreditation. An MCO's overall rating is the weighted average of the MCO's Healthcare Effectiveness Data and Information Set (HEDIS®)[6] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] measurement ratings. Plans also earn bonus points for current accreditation. The overall rating is based on a five-point scale (1=lowest performance/5=highest performance). MCOs achieve additional programs through NCQA, including the health equity accreditation. See *Table 1* for MCO accreditation, ratings, and additional programs.

Table 1: MCO Accreditation

MCO	NCQA Accredited	Overall Rating	Additional Program
WP	Yes	4	Health Equity Accreditation & Health Equity Accreditation Plus*
ABHWV	Yes	3.5	Health Equity Accreditation
THP	Yes	3.5	N/A
HHOWV	Scheduled	N/A	N/A

*Health Equity Accreditation Plus distinction recognizes organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.

Health Outcomes

HEDIS® Measures

HEDIS® is a comprehensive set of standardized performance measures designed by NCQA to assess the effectiveness of different types of health plans and provide consumers with the information they need to compare health plan performance. HEDIS® measures focus on specific clinical areas and health care processes, providing insight into various health plan areas like

[6] HEDIS is a comprehensive set of standardized performance measures designed to provide consumers with information they need to compare health plan performance.

[7] CAHPS assesses health care quality by asking patients to report their experiences with care rendered by health plan providers.

preventive care, chronic disease management, behavioral health care, utilization management, and member satisfaction.

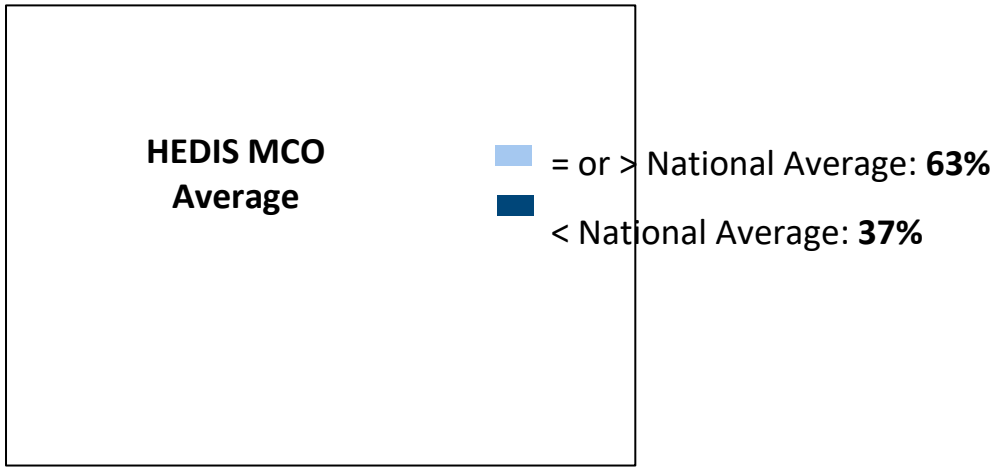
Qlarant conducted EQRO activities for all MHT MCOs and evaluated MCO compliance for measurement years (MY) 2023 and 2024, as applicable. This inclusion allows for a comparative analysis of each MCO's performance over time, highlighting trends and areas for improvement. However, due to HHOWV's August 1, 2024 start date, the MCO was unable to complete a full annual cycle of external quality review activities and solely the 24/7 Access to Care Requirements were examined. It is important to note that some HEDIS measure specifications are updated or retired, and new measures are introduced over time to better align with health data standards and support new models of care delivery. This may influence the interpretation of certain year-over-year trends.

Want to Know More?

Visit here to view HEDIS Measures from the EQRO report.

West Virginia's weighted averages were compared to the NCQA Quality Compass Medicaid MCO benchmarks. The MCOs, based on weighted averages, performed better than the national average benchmark for 63% of HEDIS® measures reported in Appendix 1 of the EQRO report (*Figure 8*).

Figure 8: West Virginia HEDIS Compared to the NCQA Quality Compass Medicaid MCO Benchmarks



Appendix 1 of the EQRO report utilizes a diamond rating system to compare West Virginia HEDIS measure results to the NCQA Quality Compass Medicaid MCO benchmarks. Measures change on an annual basis and two PIP performance measures — annual dental visits for children 2-3 years of age and percentage of eligible members that received preventive dental services — were retired on December 31, 2023, and replaced with LSC. BMS will continue to monitor and assess priority areas and select measures to further align with Medicaid programs and the Managed Care Quality Strategy goals and objectives. MCOs select their PIP measure from the Quality Strategy goals and objectives to align with the State's plan to improve health outcomes in West Virginia. This ongoing effort aims to improve the quality, timeliness, and accessibility of health care services for West Virginia's managed care beneficiaries. *Table 2* displays the number of measures, by diamond rating, that equal or exceed the NCQA Quality Compass National Average.

Table 2: MHT Performance Measures[8]

Performance Measures	MY 2023 (ATR 2024)	Comparison to National Benchmark	Measure Selection
(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents– Body Mass Index Percentile (Total)^^	91.82%	♦♦♦♦	THP-Selected PIP
(CBP) Controlling High Blood Pressure	70.75%	♦♦♦	Quality Withhold Measure
(ADD) Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	59.50%	♦♦♦	Quality Strategy Measure
(ADD) Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	54.36%	♦♦♦	Quality Strategy Measure
(FUA) Follow-Up After Emergency Department Visit for Substance Use – 30-Day Follow-Up (18+ Yrs)	49.39%	♦♦♦	Quality Strategy Measure
(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents -– Counseling for Physical Activity (Total)^^	74.97%	♦♦	THP-Selected PIP
(LSC) Lead Screening in Children^	64.23%	♦♦	State-Mandated PIP
(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder – 30-Day Follow-Up (Total)	61.25%	♦♦	Quality Strategy Measure
(WCV) Child and Adolescent Well-Care Visits (Total)^^	55.18%	♦♦	THP-Selected PIP
(FUM) Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-Up (Total)^	54.95%	♦♦	State-Mandated PIP
(WCV) Child and Adolescent Well-Care Visits (12-17 Yrs)^^	53.87%	♦♦	ABHWV-Selected PIP
(IMA) Immunizations for Adolescents – HPV^^	28.78%	♦	WP-Selected PIP
(WCV) Child and Adolescent Well-Care Visits (18-21 Yrs)^^	28.23	♦	ABHWV-Selected PIP

[8] Table legend adapted from WV 2024 ATR.

Performance Measures	MY 2023 (ATR 2024)	Comparison to National Benchmark	Measure Selection
(IMA) Immunizations for Adolescents – Combination 2^^	27.95%	♦	ABHWV + WP-Selected PIP

^ State-mandated PIP measure.
^^ MCO-selected PIP measure.
NC=Not Calculated indicates an average rate and/or comparison to benchmarks could not be calculated due to unreported data and/or no benchmark available.
♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 75th percentile but does not meet the 90th percentile.
♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass National Average but does not meet the 75th percentile.
♦ MCO rate is below the NCQA Quality Compass National Average.

Consumer Assessment of Healthcare Providers and Systems

The CAHPS®[9] survey is a tool used for measuring patient experience with health care. The survey assesses health care quality by asking patients to report on their health care experiences. The MHT program conducts annual CAHPS® surveys for adults and children. The MHT program performed, as well as or better than the national average for 86% of the MY 2023 CAHPS® survey measures — over a 10% improvement when compared to MY22. HHOWV did not conduct CAHPS® surveys for MY23 due to their August 1, 2024 start date. The MHT program was unable to compare all of the CAHPS® performance measures to the national benchmarks either because the denominator for some of the survey result calculations were less than 100 or some MCOs did not report data. BMS is actively working to improve CAHPS® scores to ensure patients receive safe, high quality, and coordinated care. *Table 3* and *Table 4* highlight survey measures from the adult and child CAHPS® surveys. To view CAHPS® measures from the EQRO report, access the report here.

[9] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Table 3: MHT CAHPS Adult Survey Performance Measures[10]

Performance Measure	MY 2023 (ATR 2024)	Comparison to National Benchmark
In the last 6 months, how often did your personal doctor spend enough time with you? (Usually + Always)	92.98%	♦♦♦
Getting Care Quickly (Usually + Always)*	84.95%	♦♦♦
Coordination of Care (Usually + Always)*	87.86%	♦♦
Rating of Personal Doctor (8+9+10)	84.21%	♦♦
Rating of Specialist Seen Most Often (8+9+10)*	77.56%	♦
Rating of All Health Care (8+9+10)	73.79%	♦

Table 4: MHT CAHPS Child Survey Performance Measures[11]

Performance Measure	MY 2023 (ATR 2024)	Comparison to National Benchmark
In the last 6 months, how often did your child's personal doctor spend enough time with your child? (Usually + Always)	94.04%	♦♦♦
Getting Care Quickly (Usually + Always)	92.41%	♦♦♦
Coordination of Care (Usually + Always)*	87.17%	♦♦♦
Rating of Personal Doctor (8+9+10)	91.45%	♦♦
Rating of All Health Care (8+9+10)	87.75%	♦

* WP data is excluded because the denominator for the survey result was less than 100 or no data provided.
NC=Not Calculated indicates an average rate and/or comparison to benchmarks could not be calculated due to unreported data and/or no benchmark available.
♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 75th percentile but does not meet the 90th percentile.
♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass National Average but does not meet the 75th percentile.
♦ MCO rate is below the NCQA Quality Compass National Average.

[10] Table legend adapted from WV 2024 ATR.
[11] Ibid.

Quality Strategy

Managed Care Quality Strategy

The BMS Office of Quality Management (OQM) is responsible for monitoring and overseeing continuous improvement of MHT. The OQM leads collaboration with internal and external stakeholders to develop quality initiatives and seek input to ensure delivery of evidence-based, high-quality health care services. OQM partners with numerous stakeholders, including advocates, legislators, providers, and MCOs. BMS also works with representatives from other state agencies, as needed, to raise issues of concern to their constituencies and share information about the managed care programs for their staff and members.

BMS's mission centers on a commitment to provide quality health care services for all West Virginia Medicaid and WVCHIP members. Pursuant to this goal, OQM developed the 2024-2027 West Virginia Managed Care Quality Strategy. The purpose of the Quality Strategy is to provide a framework to guide BMS in operationalizing a dynamic approach to assessing, monitoring, and improving the quality of health care provided by the State's MCOs. The Quality Strategy is a living document that will be updated often to align with the State's missions and goals.

The Quality Strategy focuses extensively on the following:

- Ensuring alignment of Quality Strategy goals, objectives, and measures with BMS initiatives driving health care quality, including the quality withhold program for MHT and VBP initiatives.
- Developing methods for MCOs to influence outcomes-based measures and benchmark to national performance measures.
- Establishing a foundation to continually evolve health disparities and equity initiatives in future iterations.

BMS crafted five goals (illustrated in *Figure 9*) to address West Virginia's health challenges to improve quality and health outcomes across the care continuum. In partnership with the State's MCOs, sister agencies (such as BBH and BSS), and other key stakeholders, goals were selected to reflect the needs of West Virginia's MHT and MHP populations.

Figure 9: MHT and MHP Managed Care Quality Strategy Goals

Performance measurement is key to monitoring and improving quality. Within each of the five goals identified in *Figure 9*, BMS linked individual performance measures. To the extent possible, BMS relies on national performance measures that support comparisons and benchmark performance against other national, state, and local entities. BMS requires the MCOs to report relevant measures included in NCQA HEDIS, NCQA CAHPS, the CMS Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the CMS Core Set of Health Care Quality Measures for Medicaid-Eligible Adults.

As an example, BMS selected performance measures to increase the usage of timely maternal and child health services to achieve Goal 1. Selected performance measures include, but are not limited to, improving timeliness of prenatal care, postpartum care, and monitoring low infant birth weights.

While the desired outcome at the end of SFY27 is to meet or exceed measure thresholds set by NCQA, BMS has outlined interim targets for incremental progress over the three-year course of the Managed Care Quality Strategy. This approach allows the OQM to actively coordinate and drive quality improvement and monitor progress systematically. Currently, BMS is actively monitoring year one quality measures. Details related to performance targets are found in Appendix B of the 2024-2027 Managed Care Quality Strategy.[12]

Access to high-quality health care is an essential element in fostering healthy and prosperous communities and families.[13] The quality measures selected for this strategy, paired with

[12] West Virginia DoHS, BMS. Managed Care Quality Strategy 2024-2027. July 1, 2024.

[13] West Virginia Watch. West Virginia health care ranked worst in the nation. Ellen Allen. June 27, 2024. Accessed August 15, 2025.

comprehensive managed care program reporting, monitoring, and evaluation, will support BMS in achieving its goals.

MHT Program Goals

BMS has established clear goals and objectives for the managed care programs, which are intended to drive specific, measurable, and attainable improvements in care delivery and outcomes. The State faces challenges in a number of largely preventable areas, such as high instance of SUDs, high prevalence of chronic conditions, and poor ranking in lifestyle habits and health outlook.[14] [15] According to the Centers for Disease Control and Prevention (CDC) WONDER database, West Virginia had the highest age-adjusted mortality rate per 100,000 people for all causes in 2023.[16] The goals and objectives outlined in the Quality Strategy focus on addressing avoidable health conditions that affect some of the most vulnerable populations in the state: children, the elderly, and the under-employed. The five goals identified in the Quality Strategy address these health challenges and will improve quality and health outcomes across the care continuum.

BMS is committed to a strong quality and performance improvement approach that ensures managed care programs will continue to deliver quality, accessible care to members while simultaneously driving improvement in key areas. MCOs must establish and maintain provider networks in geographically accessible locations for the populations to be served. West Virginia faces additional obstacles unique to the Mountain State, including significant professional workforce shortages[17, 18] and geographic disparities in access to care where the rural nature of the state makes it difficult to maintain medical facilities accessible to much of the population.[19] Adoption of telehealth by providers has been used as a strategy to reach larger populations and bridge health care access gaps. However, complications arise when residents of rural areas lack access to high-speed and reliable internet to complete these telehealth appointments. While challenges are significant, there are many opportunities to improve the quality of care delivered to West Virginians. BMS continuously monitors network adequacy standards to verify the sufficiency of provider networks across the state to ensure members are provided adequate access to services.

[14] America's Health Rankings. Drug deaths in West Virginia. Accessed August 22, 2025.

[15] America's Health Rankings. 2024 Annual Report, West Virginia. Accessed August 15, 2025.

[16] CDC, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed August 15, 2025

[17] West Virginia University. Medical Personnel Shortage in West Virginia. Jordan Dennison. October 31, 2024.

[18] Kaiser Family Foundation (KFF). Primary Care Health Professional Shortage Areas (HPSAs). December 31, 2024.

[19] National Library of Medicine. Challenging terrains: socio-spatial analysis of Primary Health Care Access Disparities in West Virginia. Insu Hong, Bradley Wilson, Thomson Gross, Jamison Conley, Theodore Powers. August 10, 2022.

MHT Programs and Initiatives

The MHT programs strives to innovate quality improvement programs that align with the mission of BMS. While some of these programs are mandated by CMS, others are legislated by the West Virginia Legislature and chosen specifically to address the state's unique health care needs. While BMS provides numerous programs to support members in response to diverse needs of West Virginian's enrolled in Medicaid and WVCHIP, this section highlights priority programs that align with quality strategy goals and are supported by MCO initiatives.

Improve the Health and Wellness through Use of Preventive Services

Timely preventive care helps drive improvements in health outcomes and reduces future burdens on the health care system. In SFY25, BMS prioritized programmatic improvements in maternal health care services and access to and usage of early and periodic screening, diagnostic, and treatment (EPSDT) services.

Maternal Health Care

Medicaid and WVCHIP play a significant role in providing health care coverage for pregnant and post-partum women and their infants. In West Virginia, nearly half of the births are covered by Medicaid.[20] West Virginia MCOs and collaborative partner organizations throughout the state have made notable progress in maternal health, including:

- Decreasing rates of maternal smoking with the **Baby and Me Tobacco Free** program. West Virginia has the highest rate of women who smoke while pregnant, with a rate that is nearly triple the national average.[21]
- Reducing neonatal abstinence syndrome through state-funded initiatives, such as **Drug Free Moms and Babies**.[22] The Drug Free Moms and Babies program has shown measurable success, reducing substance use among participants from 74.9% at intake to 64.2% testing negative at delivery.[23]
- Additional strategies include mandatory prenatal risk screening, expanded residential treatment programs, home visitation services, and increased access to postpartum long-acting reversible contraceptives are helping prevent recurrence and improve long-term health outcomes for mothers and infants.[3]

Transforming Maternal Health Model

On January 6, 2025, CMS announced that West Virginia was one of 15 states selected to participate in the Transforming Maternal Health Model (TMaH). West Virginia was granted a federal award of $1,000,000, to be used over a performance period of 10 years.

TMaH is a CMS model designed to focus on improving maternal health care for people enrolled in Medicaid and CHIP while also reducing overall program expenditures. The model will support

[20] March of Dimes. Peristats, 2024 Health Cards. Accessed August 15, 2025.

[21] West Virginia DoHS. Smoking and Pregnancy.

[22] West Virginia DoHS. Office of Drug Control Policy Highlights Efforts to Mitigate Impact on Substance-Exposed Infants. October 7, 2024.

[23] Ibid.

participating state Medicaid agencies in the development of a whole-person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during pregnancy.

TMaH initiatives center on three main pillars, with some required and some optional program elements. In West Virginia, focus areas[24] of the pillars include:

- **Access to care, infrastructure, and workforce capacity.** Expanding access and addressing barriers that limit resource availability. This includes fostering culturally sensitive care and empowering mothers to manage their birth experiences effectively.
- **Quality improvement and safety.** Implementing evidence-based patient safety bundles to enhance maternal and infant health outcomes. This includes tackling challenges like hypertension during pregnancy, SUDs, and cardiac conditions, as well as working toward the CMS "Birthing-Friendly" hospital designation.
- **Whole-person care delivery.** Offering tailored care plans based on physical, social, and mental health needs. This includes prenatal screenings, remote monitoring for conditions like hypertension, and connections to community organizations to address SDOH.

Maternal Health Accomplishments

BMS has already made progress in achieving TMaH model goals including, but not limited to, the following:

17 hospitals or health systems have achieved a birthing-friendly hospital designation.

Extending Medicaid to 12 months postpartum.

BMS has already implemented several required model elements and other initiatives that will contribute to the success of TMaH. The State extended Medicaid coverage from 60 days to 12 months for postpartum members, facilitated birthing-friendly hospital designations for 17 hospitals or health systems within the state, and provides comprehensive support for members with SUD, including pregnant women. BMS was granted an expansion of 1115 waiver services in January 2025 to provide additional SUD services, including, but not limited to, supported recovery-related services and quick response teams to ensure members have access to and receive appropriate care.

Early and Periodic Screening, Diagnostic, and Treatment Benefit

The MCOs are charged with ensuring MHT member access to critical and comprehensive health care services. Over the past SFY, BMS worked with the MCOs to enhance and streamline required reporting for the EPSDT benefit. States are obligated by the federal government to deliver all Medicaid services specified in Section 1905(a) that are suitable and medically required to address and improve health conditions. WVCHIP complies with EPSDT requirements for its members as required by Section 1905(a).

[24] West Virginia DoHS. West Virginia Chosen as National Leader in Transforming Maternal and Infant Health. January 9, 2025.

According to federal regulations, EPSDT offers a full range of preventive health care services for children under 21 who are covered by Medicaid. EPSDT services encompass:[25]

- **Early:** Assessing and identifying problems early. For example, a pediatrician conducts a yearly physical to monitor a child's growth and development.
- **Periodic:** Checking children's health at periodic, age-appropriate intervals. For example, a child visits their dentist every six months to monitor their growth.
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
- **Diagnostic:** Performing diagnostic tests to follow-up when a risk is identified. For example, if a provider notices that a child might have some vision impairment, EPSDT would allow the provider to perform diagnostic testing to determine the root cause.
- **Treatment:** Control, correct, or reduce health problems found. For example, if a child is determined to have hearing loss, EPSDT will pay for the child's hearing aid.

Two key EPSDT metrics that CMS, BMS, and the MCOs monitor are the screening ratio and the participation ratio.

- The screening ratio reflects the extent to which beneficiaries received the recommended number of well-child screenings during the year. The screening ratio is calculated by dividing the number of screenings performed by the number of screenings expected.
- The participation ratio is calculated by dividing the number of members who received a screening or medical examination by the number of members who should have received the screening or medical examination.
- Both ratios are important to determine the overall number of screenings performed by each MCO and to determine the percentage of children receiving the recommended/required screenings.[26]

Table 5 compares the MHT program's screening and participation ratio metrics to the national average. BMS and the MCOs actively monitor program activities and performance metrics to create strategies and initiatives to promote the EPSDT benefit and improve health outcomes.

Table 5: MHT EPSDT Metrics

Metric	WV Average*	National Average**
Screening Ratio	59%	62%
Participation Ratio	49%	51%

*Data are Myers and Stauffer/BMS calculated by MCO reporting for FFY24 (October 1, 2023-September 30, 2024).
** Data is CMS calculated by MCO reporting for FFY23 (October 1, 2022-September 30, 2023).

[25] Medicaid.gov. Early and Periodic Screening, Diagnostic, and Treatment.
[26] MCO-reported data.

As shown in *Table 5*, the MHT program is underperforming compared to the national average for screening and participation ratios. However, the MCOs have identified several barriers to improving EPSDT rates:

- Transportation and access in rural areas.
- Limited appointment availability for well-care visits compared to sick visits.
- Providers who extend their hours often focus on acute care rather than preventive services.
- Underutilization of school-based health clinics.
- Gap in education for parents and adolescents about the importance of well-care visits.

Despite the above challenges, the MHT program is actively developing targeted strategies, outreach initiatives, and community partnerships to enhance EPSDT screening and participation rates.

Reduce Burden of Chronic Disease

BMS seeks to address chronic health conditions by focusing on some of the most pressing chronic conditions affecting Medicaid and WVCHIP members. West Virginia ranks second highest in the nation for disease risk factors and prevalence. According to the CDC, West Virginia has the third highest chronic lower respiratory disease mortality rate (60.07 deaths per 100,000 state residents) and the highest diabetes mortality rate (41.7 deaths per 100,000 state residents), in a three year average from 2019-2021.[27] Among West Virginia Medicaid members age 18 and over, 15.7% had a diagnosis of type 1 or type 2 diabetes in 2023, compared to the U.S. population average of 11.6%.[28]

[27] CDC. National Diabetes Statistics Report. May 15, 2024. Accessed February 15, 2024.
[28] BMS enterprise data solution claims data received and paid as of February 29, 2024.

Measure of Success: Reducing Chronic Disease

In SFY25, West Virginia MCOs focused strategies on reducing the burden of chronic disease, including the following example programs:

ABHWV – Continued enhancement of incentive programs to members who achieve timely and recommended preventive care and care related to chronic disease management.

HHOWV – Offered family supports that connect children with enriching opportunities, such as assistance finding 4H camps to promote active learning and healthy development.

THP – Successfully conducted outreach activities for members with gaps in care, including dental screening, immunizations, WCVs, cancer screenings, and lead screening.

WP – Empowered community members through Diabetes Empowerment Education Program classes and youth vaping prevention efforts involving direct interaction with over 3,500 students.

Improve Behavioral Health Outcomes

Improving behavioral health outcomes among West Virginia's Medicaid and WVCHIP population is a priority area for BMS. Medicaid shares a disproportionate cost for mental health services. According to the most recent data from the Kaiser Family Foundation, 34.3% of adults who experienced mental illness are covered by Medicaid, compared to 21.6% nationally.[29]

Certified Community Behavioral Health Clinics

During the 2022 West Virginia Legislative Session, SB 247 legislated that BMS would develop, seek approval of, and implement a Medicaid State Plan amendment (SPA) to create a system of CCBHCs. This SPA was approved by CMS on January 8, 2025, with an effective date of October 1, 2024.

CCBHC services include a comprehensive set of outpatient community-based behavioral health services and supports for individuals across the life span that are delivered in an integrated, whole-person approach, including consideration for the needs of Veterans and uniformed officers, through coordination across behavioral health, physical health, and social service providers. All CCBHC services are furnished by qualified practitioners affiliated with West Virginia's CCBHCs. The service(s) must actively benefit the member and be described in the member's treatment plan.[30]

The West Virginia CCBHC program officially launched on October 1, 2024. Six Medicaid providers were selected for participation in this program:

- Southern Highlands Community Mental Health Center.
- FMRS Health Systems, Inc.
- Seneca Health Services, Inc.
- Valley Healthcare System.
- Prestera Center.
- Westbrook Health Services.

[29] KFF. Mental Health in West Virginia Fact Sheet. National Survey on Drug Use and Health 2018-2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt32808/2019NSDUHsaeMethodology/2019NSDUHsaeMethodology/2019NSDUHsaeMethodology.pdf

[30] West Virginia DoHS. SPA 24-0001 Certified Community Behavioral Health Clinic (CCBHC) Services. February 19, 2024.

Measure of Success: Behavioral Health

During SFY25, MCOs implemented various strategies to address behavioral health, including the following:

ABHWV – Initiated live outreach to adult members recently discharged from the emergency department with diagnosis of mental illness or intentional self-harm to facilitate seven-day follow-up with primary care or behavioral health providers.

HHOWV – Education and treatment referrals to resources promoting use of pharmacotherapy.

THP – Implemented a new clinical platform that has increased overall engagement to better assist members with obtaining the services they need, allowing THP to establish an initial texting relationship with the members that then transitions into phone calls once they feel comfortable discussing their stories verbally.

WP – Implemented program offering online confidential cognitive behavioral therapy for ages 13 and above with 24/7 clinician coaching to address common mental health issues and break down barriers to care access. WP reduced emergency room visits among youth and adolescents related to behavioral health services.

Reduce Burden of Substance Use Disorder

In January 2025, BMS received approval to extend additional services through the State's 1115(a) waiver (Evolving West Virginia Medicaid's Behavioral Health Continuum of Care). The waiver provides expanded recovery and support services for members with SUD needs. The waiver additionally includes expanded peer recovery support specialty services, which was a key area of focus for MCOs in SFY25.

BMS continues to prioritize efforts to address SUD prevention and treatment and works collaboratively with the MCOs to collect data and track performance on measures to assess the impact of the SUD-related programs and interventions. BMS has prioritized measures aimed at treatment and recovery efforts to align with BMS priorities around the SUD efforts, such as emphasizing prevention, community engagement, support, and research as integral components of the State's approach to addressing SUD.

Measure of Success: Substance Use Disorder

During SFY25, MCOs implemented various strategies to address SUD, including the following:

ABHWV – Implemented an outreach campaign for members recently discharged from high-intensity care settings for substance use. MCOs provided education to members on the importance of regular appointments with the member's health care team.

HHOWV – Implemented an Opioid Management Program, where a team of medical directors and pharmacists met monthly to make recommendations to providers prescribing opioids and provide education to members around safe medication use.

THP – Prioritized alignment with Peer Support Specialists to support members diagnosed with an SUD throughout their recovery journey.

WP – Provided case management services to residential addiction facilities to assist members in understanding and accessing their benefits, assessing post-discharge needs, and assisting with discharge planning in coordination with the

Senate Bill 820 Quality Programs

In SFY24, the West Virginia Legislature passed SB 820. SB 820 charged BMS with developing and implementing programs to improve quality of care rendered to Medicaid members with SUD through a comprehensive, three-pronged approach:

- Establish a managed care quality withhold program.
- Ensure automatic member enrollment.
- Require managed care reporting of inpatient SUD measures.

Quality Withhold Program

In SFY25, BMS began implementation of a managed care quality withhold program based on nationally recognized measures of performance outcomes, including those related to SUD inpatient care. BMS selected HEDIS measures for the quality withhold program and aligned the quality withhold measures shown in *Table 6* with performance measures selected for the Quality Strategy.

Table 6: Quality Withhold Program Measures

Quality Withhold Measures		
	Acronym	**Measure**
1.	FUI	Follow-Up After High-Intensity Care for SUD (7 Days Total)
2.	OED	Oral Evaluation, Dental Services (Ages <1 to 20)
3.	CBP	Controlling High Blood Pressure

Quality Withhold Measures		
	Acronym	Measure
4.	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
5.	W30	Well-Child Visits in the First 30 Months of Life (0-15 Months)

HHOWV entered the West Virginia Medicaid market on August 1, 2024. HHOWV's first HEDIS submission is expected to be in June 2026 for MY25. BMS has designated a set of operational performance metrics that will be used in lieu of HEDIS measures for any new MCO. BMS anticipates that HHOWV will report baseline data for MY25 and then transition to the quality measures once they have a second year of HEDIS reporting to compare to the baseline.

The quality withhold program is designed to drive quality improvement while being straightforward to administer. Beginning July 1, 2025, BMS will withhold 1% of monthly capitation, excluding tax funding and delivery case rates. To earn back the money withheld, the MCOs will need to demonstrate year-over-year improvement. BMS will continue to monitor MCO performance through SFY26. Information on MCO performance through the first year of the quality withhold will be included in the SFY26 MHT Annual Report.

Automatic Enrollment

Additionally, SB 820 mandated that BMS "create a program to improve quality of care rendered to the substance use disorder population by applying automatic enrollment to the managed care population." Throughout SFY25, BMS worked with multiple stakeholders to implement an automatic enrollment process. Day-one enrollment officially began on July 1, 2025, after a comprehensive readiness review assessing vendor completion of key tasks and thorough systems testing. Automatic day-one enrollment offers a variety of benefits to members, providers, MCOs, and BMS, including:

- Enrollment of members in managed care that is effective the first day of the month they gain Medicaid or WVCHIP eligibility.
- Timely access to coordinated care and resources for members with SUDs.
- The opportunity for MCOs to immediately coordinate care and treatment in the most appropriate setting.
- Avoidance of delays in provider initiation of critical assessments and development of treatment plans.
- Managed care program cost savings through earlier treatment and care coordination, coupled with the performance improvement initiatives implemented for inpatient SUD providers and the MCOs.

Inpatient SUD Provider Measures

SB 820 requires BMS to develop and implement outcome measures for SUD inpatient providers. These measures are designed to help ensure the effectiveness and accountability of care, with the goal of improving treatment outcomes for individuals with SUD. Over the past SFY, eight measures have been agreed upon between BMS and a newly established advisory committee, comprised of MCOs and the provider community.

Mobile Crisis Intervention

BMS implemented mobile crisis intervention services for Medicaid members in July 2024. The benefit provides members experiencing a suspected mental health and/or SUD-related crisis timely intervention services and supports, stabilization of the crisis event, and time-limited rehabilitation intervention services. BMS offers a toll-free crisis hotline service and member access to mobile crisis response teams throughout the state, staffed 24 hours per day, seven days a week. Mobile crisis services aim to help members return to previous levels of functioning, develop coping mechanisms to minimize or prevent future crises, and prevent unnecessary institutionalization.[31] The services are an important addition to the delivery system, meeting individuals in their communities during the time of crisis. Intervention services will link members to resources and engage them in treatment that will support long-term success.

Whole Person Wellness

Social Determinants of Health

In January 2021, BMS required MCOs to develop strategies and initiatives targeting SDOH. SDOH encompass the conditions in the environments where people are born, live, learn, work, play, worship, and age and they significantly impact health, functioning, and quality of life outcomes.[32] SDOH includes factors, such as housing, education, income, transportation, food security, employment/workforce development, education, childhood experiences, behavior, access to care, and environment. Addressing SDOH is especially important for Medicaid and WVCHIP populations as research indicates that these interventions improve long-term health outcomes and reduce disparities.[33]

The SDOH strategies are aimed at enhancing integrated physical and behavioral health care, promoting active local involvement, and focusing on enrollees and their families through proactive case management. MCOs must ensure their strategies meet criteria for improving health care quality and include these expenditures in the medical loss ratio, which ensures funds are spent directly on Medicaid enrollees.

[31] West Virginia BMS. State Plan Amendment 23-0003, Medicaid Community-Based Mobile Crisis Intervention Services Program. September 5, 2023. Accessed on February 15, 2024.

[32] Bureau for Medical Services, Model Purchase of Service Provider Agreement.

[33] KFF. Medicaid Authorities and Options to Address Social Determinants of Health. Elizabeth Hinton, Amaya Diana. January 29, 2024.

Measure of Success: MCO Community Support

During SFY25, MCOs implemented various strategies to address SDOH including the following:

ABHWV – Collaborated with Community Health Worker programs to address the needs of members with chronic conditions and address SDOH including food assistance, transportation access, financial assistance, and other non-clinical barriers to wellness.

HHOWV – Invested in community health through the launch of a farmers market pilot program aimed to improve food security and heathier communities in the Charleston area.

THP – Implemented a food as medicine project that provides fruits and vegetables to members for regularly engaging with their primary care physician to monitor health metrics.

WP – Established "food as medicine" initiatives that provide members the opportunity to purchase fruits and vegetables through pop-up "FARMacies," regularly engage their primary care provider to monitor health metrics, and engage schools to implement health and wellness programs.

Program Integrity

The BMS Office of Program Integrity (OPI) remains steadfast in its mission to identify, prevent, and mitigate fraud, waste, and abuse within the West Virginia Medicaid and WVCHIP programs. As the steward of program integrity, OPI ensures that Medicaid services are billed and administered in accordance with all applicable standards, while safeguarding public health care funds through strategic partnerships with MCOs, as well as state and federal law enforcement agencies, including the Medicaid Fraud Control Unit.

In SFY25, BMS advanced its direct coordination with MHT and enforcement agencies, fostering enhanced communication, stronger investigative collaboration, and more efficient identification and resolution of integrity concerns. These partnerships have enabled the timely recovery of overpayments and fortified long-term safeguards against fraudulent or improper activities within the program.

BMS continues to recognize and commend the sustained commitment of MHT in reinforcing Medicaid Program Integrity through the following key actions:

- Initiation of comprehensive audits to proactively detect billing discrepancies.
- Referral of credible fraud allegations to appropriate investigative entities.
- Delivery of targeted education and outreach to providers to improve compliance and billing accuracy.

Program Integrity Metrics

Throughout SFY25, BMS observed the program integrity activities of all MCOs within the MHT and MHP programs (*Table 7*). Metrics include the number of new audits initiated, number of fraud referrals, and total overpayment recoveries.[34]

Table 7: Program Integrity Metrics

SFY25 Program Integrity Metrics	
Metric	**Total**
Number of New Audits Initiated	697
Fraud Referrals	22
Overpayment Recoveries	$1,423,475.20

SFY24 Program Integrity Metrics	
Metric	**Total**
Number of New Audits Initiated	297
Fraud Referrals	23
Overpayment Recoveries	$1,345,549.26

SFY23 Program Integrity Metrics	
Metric	**Total**
Number of New Audits Initiated	218
Fraud Referrals	35
Overpayment Recoveries	$1,503,543.36

A notable development in SFY25 has been the expansion of prepayment reviews. These reviews are strategically focused on providers with histories of suspected billing irregularities, effectively reducing improper payments while concurrently offering opportunities for provider education and corrective action. Prepayment strategies are carefully aligned with law enforcement priorities to avoid interference with ongoing investigations while maintaining strong financial oversight. Additionally, BMS worked closely with HHOWV to prepare the MCO with clear expectations and provide necessary tools and resources to ensure the MCO can effectively navigate and complete the onboarding process. This proactive engagement has helped HHOWV align with State integrity standards from the outset, supporting a consistent approach to compliance across all contracted entities.

[34] SFY23 overpayment recovery data is not available. SFY22 data is reported based on data provided in the SFY22 annual report and, due to change in reporting platforms, cannot be verified for SFY24.

Through these combined efforts — referrals, education, prepayment reviews, and the onboarding of new Plans — BMS, in collaboration with the Managed Care Plans, continues to enhance provider compliance and strengthen the overall integrity of the West Virginia Medicaid program. These initiatives not only protect public funds but also help ensure services remain available and accessible to the state's most vulnerable populations.

Additional Resources

West Virginia Medicaid Resources

- DoHS Bureau for Medical Services
- West Virginia Department of Human Services
- Mountain Health Trust
- Centers for Medicare & Medicaid Services
- Medicaid.gov
- Your Guide to Medicaid
- 2024-2027 Managed Care Quality Strategy

Federal Medicaid Funding

- Financial Management of Medicaid Services

West Virginia External Quality Review Results

- 2024 Annual Technical Report
- NCQA Accreditation Process
- NCQA's Health Plan Report Card for West Virginia
- West Virginia DoHS Overview of all Medicaid Reports

National Quality Measures

- Adult Health Care Quality Measures
- Children Health Care Quality Measures

Contact Information

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350 Capitol Street, Room 251
Charleston, WV 25301
Phone: (304) 558-1700
https://wv.accessgov.com/bms/Forms/Page/contactbms/contact-bms/

Aetna Better Health of West Virginia, Inc.
500 Virginia Street East, Suite 400
Charleston, WV 25301
www.aetnabetterhealth.com/westvirginia

Wellpoint Health Plan of West Virginia, Inc.
200 Association Drive, Suite 200
Charleston, WV 25311
www.wellpoint.com/wv/medicaid

The Health Plan, Inc.
1110 Main Street
Wheeling, WV 26003
www.healthplan.org

Highmark Health Options of West Virginia, Inc.
614 Market St.
Parkersburg, WV 26101
https://wv.highmarkhealthoptions.com

Appendix

Acronyms List

Acronym	Definition
ABHWV	Aetna Better Health of West Virginia
ADD	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder ADHD Medication
ATR	Annual Technical Report
BBH	Bureau for Behavioral Health
BMS	Bureau for Medical Services
BSS	Bureau for Social Services
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBP	Controlling High Blood Pressure
CCBHC	Certified community behavioral health clinic
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DoHS	Department of Human Services
DPP	Directed payment program
EPSDT	Early and periodic screening, diagnostic, and treatment
EQR/EQRO	External quality review/external quality review organization
FFS	Fee-for-service
FFY	Federal fiscal year
FMAP	Federal Medical Assistance Percentage
HEDIS	Healthcare Effectiveness Data and Information Set
HHOWV	Highmark Health Options West Virginia
IMA	Immunizations for adolescents
LSC	Lead Screening in Children
MCO	Managed care organization
MHP	Mountain Health Promise Program
MHT	Mountain Health Trust Program
MSFAC	Medical Services Fund Advisory Council
MY	Measurement year

Acronym	Definition
NCQA	National Committee for Quality Assurance
OPI	Office of Program Integrity
OQM	Office of Quality Management
PHE	Public health emergency
PIP	Performance Improvement Project
SB	Senate Bill
SDOH	Social determinants of health
SFY	State fiscal year
SPA	State Plan amendment
SSA	Social Security Act
SSI	Supplemental Security Income
SUD	Substance use disorder
TANF	Temporary Assistance for Needy Families
THP	The Health Plan
TMaH	Transforming Maternal Health Model
VBP	Value-based payment
WVCHIP	West Virginia Children's Health Insurance Program