



West Virginia Department of
Human Services

**Managed Care
Quality Strategy
2024-2027**



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Section 1: Introduction and Overview

The 2024-2027 West Virginia Managed Care Quality Strategy (Managed Care Quality Strategy) is a framework to guide the West Virginia Department of Human Services (DoHS), Bureau for Medical Services (BMS), in providing quality health care services for all West Virginia Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) members enrolled in managed care. BMS is the single state agency responsible for administering the Medicaid program and WVCHIP programs, and BMS' Office of Quality Management (OQM) is responsible for monitoring and overseeing continuous improvement of the State's two Medicaid managed care programs, Mountain Health Trust (MHT) and Mountain Health Promise (MHP). MHT and MHP are administered by BMS' Office of Managed Care.

The purpose of the BMS Managed Care Quality Strategy is to:

- Serve as a tool and resource that articulates the DoHS and the BMS vision for delivery of health care services.
- Provide a proactive, data-driven strategy for BMS to improve health outcomes for Medicaid and WVCHIP members by strengthening quality and performance improvement.
- Provide a framework for assessing and improving the quality of health care and services furnished by managed care organizations (MCOs) in accordance with [42 Code of Federal Regulation \(CFR\) §438.340](#) and [42 CFR §457.1240](#). Required CFR elements are listed in [Appendix A](#).
- Align with the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy.
- Serve as a roadmap for operationalizing a dynamic approach to assessing, monitoring, and improving the quality of health care provided under managed care.

As illustrated in *Figure 1*, the BMS mission centers on a commitment to administering the Medicaid program that emphasizes maintaining accountability for the use of resources in a manner that ensures access to appropriate, medically necessary, and quality health care services for all members. BMS provides services in a user-friendly manner to members and providers alike in the appropriate setting and focuses on the future by providing preventive care programs.¹

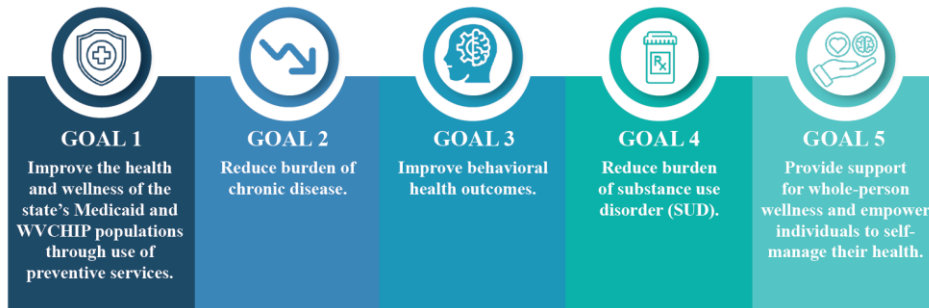
¹ West Virginia BMS (n.d.). [About Us](#). Accessed on January 31, 2024.

Figure 1: West Virginia BMS Mission



The Managed Care Quality Strategy aims to further the mission by defining the goals and objectives of West Virginia’s Medicaid and WVCHIP managed care programs to drive improvements in care delivery and the outcomes and metrics by which progress will be measured. It sets a clear direction for priority interventions and details the standards and mechanisms for BMS to work with the MCOs to achieve desired outcomes. Combined with the proper prioritization of performance improvement projects (PIPs) and value-based programs, the MCOs will work to improve care provided to members and thereby improve overall managed care health outcomes in West Virginia. The 2024-2027 Managed Care Quality Strategy goals are detailed in Figure 2 and further described in Section 3.

Figure 2: West Virginia Managed Care Quality Strategy Goals



The BMS has developed a Managed Care Quality Strategy that focuses extensively on the following:

- Ensuring alignment of the Managed Care Quality Strategy’s goals, objectives, and measures with BMS initiatives driving health care quality, including a performance or quality withhold program for the MHT program and value-based payment initiatives.
- Developing methods for MCOs to influence outcomes-based measures and benchmark to national performance measures.

Within each of the five goals identified in *Figure 2*, the BMS has defined specific objectives linked to individual performance measures. These objectives establish a target for improvement that reflects national benchmarks (e.g., National Committee for Quality Assurance [NCQA] Healthcare Effectiveness Data and Information Set [HEDIS[®]] Medicaid national average).² While the desired outcome at the end of state fiscal year (SFY) 2027 is to meet or exceed measure thresholds, BMS has outlined interim targets for incremental progress over the course of the three years of this Managed Care Quality Strategy. This approach allows the OQM to actively coordinate and drive quality improvement and monitor progress systematically. The BMS may update the list of selected quality measures as measures are added or retired by NCQA and amend benchmarks as targets are achieved, as appropriate. Details related to performance targets can be found in [Appendix B](#), which provides a tracking tool to measure data-driven progress toward achievement of Managed Care Quality Strategy goals. A comprehensive list of quality measures outlined in Appendix B will be made available at least annually on the [BMS website](#). Detailed planning regarding monitoring quality improvement is outlined further in an implementation and maintenance plan in [Appendix C](#).

1.1 West Virginia Medicaid and WVCHIP Program Overview

Since 1996, the BMS Office of Managed Care has operated a risk-based Medicaid managed care program that has grown into the predominant service delivery model through MHT and MHP. BMS contracts with MCOs for the provision of medically necessary services for members, including acute and preventive health care services, as well as valuable support to help members manage their health care (e.g., care coordination). Additionally, the MCOs provide a wide range of supplementary services, including coordination with social services such as housing and nutrition, non-emergency medical transportation (NEMT), and health education.

In SFY 2025, 82% of Medicaid members were enrolled in the MHT and MHP programs, while 18% received services through the fee-for-service (FFS) delivery system.³ The majority of FFS members are receiving long-term services and supports (LTSS) through enrollment in home and community-based services (HCBS) waiver programs. With the exception of qualifying children with serious emotional disorders, individuals who are eligible for MHP can opt out of managed care to be served under FFS. [The following](#) is an overview of the MHT and MHP programs, which are included in the scope of the Managed Care Quality Strategy.

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1.1.1 MHT Program

The MHT program provides essential health care coverage to children and adults with low income and eligible individuals with disabilities who are enrolled in Medicaid. Under the Affordable Care Act (ACA), West Virginia expanded coverage and integrated these expansion members into the MHT delivery system. These populations are enrolled in the MHT program under Section 1915(b) waiver authority of the [Social Security Act of 1981, Sec. 1915. \[42 U.S.C. 1396n\]](#). As of June 2025, MHT serves approximately 386,406 members.⁴

WVCHIP members participate in managed care through Title XXI State Plan authority. Over 25,000 children under the age of 19 and pregnant women are enrolled in WVCHIP.⁵ WVCHIP members began participation in MHT on January 1, 2021. As of July 1, 2023 (SFY 2024),

² HEDIS[®] is a comprehensive set of standardized performance measures designed to provide consumers with information they need to compare health plan performance.

³ West Virginia BMS SFY 2025 Enrollment Data.

⁴ West Virginia Medicaid. [Managed Care and Fee For Service Monthly Report 2025](#).

⁵ Ibid.



WVCHIP adopted the Medicaid benefits package for medical, behavioral, and dental health services and was consolidated into the MHT MCO contract with Medicaid. On July 1, 2024, WVCHIP adopted the Medicaid pharmacy benefit.

In October 2023, BMS issued a Request for Application for interested vendors to submit applications to serve as additional MHT MCOs. Highmark Health Options West Virginia (HHOWV) was selected to provide services for eligible MHT members. HHOWV began receiving Medicaid membership on August 1, 2024.

As of September 2025, the MHT market share consists of four MCOs: Aetna Better Health of West Virginia (35%), HHOWV (3%), The Health Plan of West Virginia (25%), and Wellpoint Health Plan of West Virginia, formerly UniCare (37%).⁶

1.1.2 MHP Program

MHP is a specialized managed care program that BMS implemented in March 2020, under Section 1915(b) waiver authority of the [Social Security Act of 1981, Sec. 1915. \[42 U.S.C. 1396n\]](#). As of February 2024,⁷ MHP serves approximately 26,658 children and youth in the following populations:

- Children and youth in foster care or the adoption assistance program, which includes kinship care and legal guardianship.
- Former foster care youth up to age 26.
- Children ages three to 21 who are concurrently enrolled in the West Virginia Children with Serious Emotional Disorders 1915(c) Waiver (CSEDW), which provides an array of HCBS services that enable children to remain in their home and community.

The BMS contracts with one MCO for the provision and coordination of MHP services. The BMS and the MHP MCO also coordinate with the West Virginia Bureau for Social Services (BSS) and the Office of Inspector General's Foster Care Ombudsman to support the MHP population and to advocate for the rights of eligible children and youth across programs and state agencies. Additionally, the Office of Constituent Services provides support in the form of prompt and accurate reporting services for questions regarding member benefits.

1.2 BMS OQM and Collaboration with Stakeholders

The BMS Office of Managed Care coordinates closely with the OQM to achieve quality-related goals for the MHT and MHP programs. The BMS organizational chart is found in [Appendix E](#).

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, MCOs, and the BMS enrollment broker. 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 convened a stakeholder workgroup specific to the development and review of this updated Managed Care Quality Strategy. The workgroup composition, structure, and activities are further detailed in [Section 2](#).

⁶ BMS SFY 2025 Data.

⁷ Ibid.



The BMS [Medical Services Fund Advisory Council \(MSFAC\)](#)⁸ meets quarterly to provide input on the direction of managed care quality activities. The MSFAC includes providers, members, legislators, and agency staff, who meet on a quarterly basis to advise the BMS on a range of issues, including providing feedback on quality activities and programs. In 2025, the BMS established a [Beneficiary Advisory Council \(BAC\)](#), comprised of current and former Medicaid and WVCHIP members, their families, caregivers, and guardians the opportunity to share input and advise BMS on matters related to the effective administration of the Medicaid program. In accordance with [42 CFR §431.12](#), BMS ensures the MSFAC has adequate representation from BAC members.

Historically, WVCHIP's Board of Directors supported the WVCHIP program by developing plans to provide health services specific to the needs of children. WVCHIP's Deputy Commissioner engaged the Board of Directors in activities critical to the administration of WVCHIP, including implementing policies and procedures and monitoring financial, quality, and care delivery metrics. BMS has reconfigured the WVCHIP Board of Directors to align more closely with MSFAC.

The CSEDW Quality Improvement Advisory (QIA) Council advises and assists BMS and the MCOs in program planning, development, and evaluation for the program. This council utilizes an evidence-based Quality Improvement System and incorporates a broad base of stakeholders in active roles in the process. These activities are further described in [Section 4](#).

West Virginia does not have federally recognized tribes located in the state; therefore, the BMS does not receive consultation from tribal representatives on the Managed Care Quality Strategy as required in [42 CFR §438.340](#).

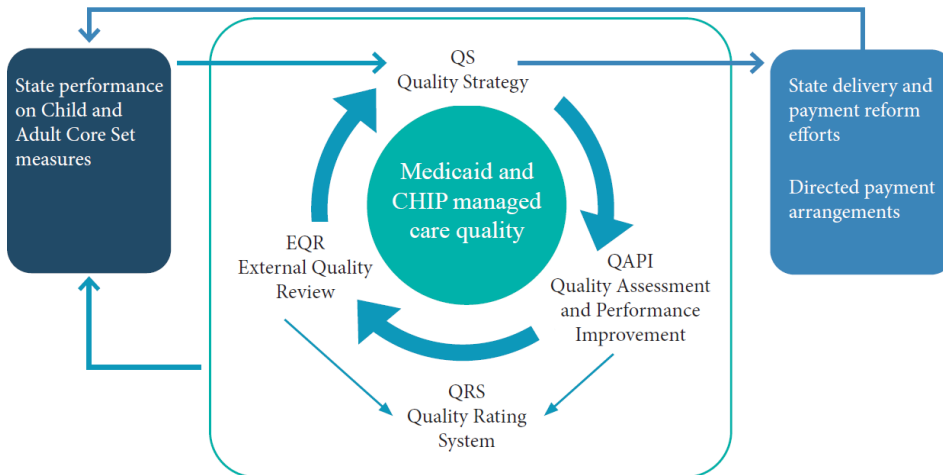
⁸ The West Virginia MSFAC serves as the state's Medical Advisory Committee under 42 CFR §431.12.

Section 2: Development, Review, and Revision of Managed Care Quality Strategy

The BMS developed this Managed Care Quality Strategy in accordance with [42 CFR §438.340](#) and [42 CFR §457.1240](#). To ensure compliance with the regulatory requirements in the 2021 CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit, [Appendix A](#) provides a crosswalk of each required element and the corresponding section of the Managed Care Quality Strategy where the element is located.

According to the CMS, the quality strategy is part of a multipronged approach to managed care quality that is best implemented when aligned with use of other key quality tools and initiatives, such as the Medicaid and CHIP Adult⁹ and Child¹⁰ Core Set measure reporting; NCQA HEDIS[®] and Consumer Assessment of Healthcare Providers and Systems (CAHPS[®])¹¹ reporting; PIPs, as part of Quality Assessment and Performance Improvement (QAPI) programs; value-based purchasing initiatives; and annual External Quality Review (EQR).¹² As illustrated in *Figure 3*, these tools and initiatives are interrelated, with each one informing and reinforcing the others.¹³

Figure 3: Relationship Between State Medicaid and CHIP Managed Care Quality Initiatives



2.1 Process for Reviewing and Updating the Managed Care Quality Strategy

The OQM is responsible for maintaining and updating the State’s Medicaid and WVCHIP Managed Care Quality Strategy. The OQM, in consultation with a multidisciplinary group of stakeholders, developed the key priority areas and measures included in this Managed Care Quality

⁹ Medicaid.gov. [Child and Adult Health Care Quality Measures, Adult Core Set](#). Accessed on January 31, 2024.

¹⁰ Ibid.

¹¹ CAHPS[®] assesses health care quality by asking patients to report their experiences with care rendered by health plan providers.

¹² See 42 CFR §438.330, §438.334, §438.6(c), §438.350, §457.1240(b), §457.1240(d), and §457.1250 for more information on QAPI, state directed payments, and EQR.

¹³ Medicaid.gov. [Medicaid and Children’s Health Insurance Program \(CHIP\) Managed Care Quality Strategy Toolkit](#). June 2021. Accessed on January 31, 2024.

Strategy. The BMS updates the Managed Care Quality Strategy for CMS to review on a triennial basis, or more frequently when there is a significant change to the Medicaid and/or WVCHIP programs. The BMS defines a significant change as the following:

- Changes in MCO operation that impact adequate capacity and services, including, but not limited, to benefits, geographic service areas, or payments.
- Enrollment of a new population group in the managed care program.

The OQM is responsible for reviewing program changes to determine the level of significance and if revisions to the Managed Care Quality Strategy are necessary.

The BMS formally assesses the Managed Care Quality Strategy annually to track progress toward meeting goals and objectives. The State reviews recommendations of its contracted External Quality Review Organization (EQRO) to identify areas of deficiency and approaches to improve the quality, appropriateness, and access to health care services for Medicaid and WVCHIP members. The EQRO is also instrumental in identifying performance measures that best reflect the State's goals. The BMS also takes into account the MCO's QAPI programs and the MCO reporting when updating the Managed Care Quality Strategy. The BMS reviews available data throughout the year to address early warning signs or issues that arise.

In September 2025, the BMS performed an update of the 2024-2027 Quality Strategy to revise targeted interventions and strategies and address compliance with federal regulations.

2.1.1 Stakeholder Workgroup

The process for developing the Managed Care Quality Strategy promotes meaningful improvement in clinical and preventive health affecting MHT and MHP members. It also provides a wide range of stakeholders with the opportunity to review and provide feedback. In November 2023, BMS convened a stakeholder workgroup that consisted of representatives from the BMS (including WVCHIP), MCOs, the Bureau for Public Health, the Bureau for Behavioral Health (BBH), and BSS. The workgroup assisted in review of required quality strategy elements and analysis of the 2024-2027 Managed Care Quality Strategy to provide recommendations for selection of meaningful measures applicable to the populations served that align with the State's priorities and CMS strategies. Additionally, the BMS requested feedback from the MSFAC.

2.1.2 Public Comment

The BMS sought input from members and other stakeholders on the Managed Care Quality Strategy draft through a public comment period. The draft Managed Care Quality Strategy was posted to the [BMS website](#) in April 2024, in accordance with federal regulations for public notice and availability of information, allowing a minimum of 30 days for stakeholder input and written feedback. The BMS received public comment and took input into consideration during development of the 2024-2027 Managed Care Quality Strategy.

Section 3: Goals and Objectives

The BMS has established clear goals and objectives for the Managed Care Quality Strategy which are intended to drive specific, measurable, and attainable improvements in care delivery and outcomes. These goals and objectives were selected in collaboration with stakeholders to reflect the needs of West Virginia's Medicaid and WVCHIP populations. West Virginia is a rural state and the only state in the nation completely within the Appalachia region. The West Virginia population totals approximately 1.77 million.¹⁴ Medicaid and WVCHIP cover an estimated 503,487 individuals, which is nearly a third of the state's population.¹⁵

The State faces challenges in a number of largely preventable areas. America's Health Rankings cited poor rankings for substance use disorders (SUDs), prevalence of chronic conditions, and lifestyle habits, such as smoking, affecting health outcomes.¹⁶ According to a 2023 Centers for Disease Control and Prevention (CDC) report of resident deaths, West Virginia had the third highest age-adjusted mortality rate per 100,000 people for all causes. West Virginia also had the highest age-adjusted mortality rates for all accidental deaths, diabetes, and drug overdose deaths.^{17,18,19} West Virginia has seen a 41% reduction in overdose deaths in 2025.²⁰ The goals and objectives outlined in the Managed Care Quality Strategy focus on addressing these avoidable health conditions that affect some of the most vulnerable populations in the state: children, the elderly, and the under-employed.

The BMS created five goals to address West Virginia's health challenges and to align with goals identified by the CMS National Quality Strategy to improve quality and health outcomes across the care continuum.²¹ The BMS also identified specific objectives with the intent of increasing focus for targeted progress in achieving each goal. Together, the goals and objectives create a framework for West Virginia to drive the overall vision for advancing quality health care for MHT and MHP members. *Table 1* below represents the West Virginia Managed Care Quality Strategy Goals and Objectives for 2024-2027.

¹⁴ United States Census Bureau. [State Population Totals and Components of Change: 2020-2024](#). December 18, 2023. Accessed on June 7, 2024.

¹⁵ BMS SFY 2025 Data.

¹⁶ America's Health Rankings. [2021 Annual Report, West Virginia](#). Accessed on February 15, 2024.

¹⁷ CDC. [Accident Mortality by State, 2022](#). February 10, 2023. Accessed on February 15, 2024.






¹⁸ CDC. [Drug Overdose Mortality by State, 2022](#). March 1, 2022. Accessed on February 15, 2024.

¹⁹ CDC. [Diabetes Mortality by State, 2022](#). March 1, 2022. Accessed on February 15, 2024.

²⁰ [West Virginia Leads Nation in Reducing Overdose Deaths, 2025](#). Accessed on September 15, 2025.

²¹ CMS. [CMS National Quality Strategy](#). Page last modified April 5, 2024. Accessed on February 15, 2024.

Table 1: West Virginia 2024-2027 Managed Care Quality Strategy Goals and Objectives

	Goal	Objectives
	Goal 1: Improve the health and wellness of the state’s Medicaid and WVCHIP populations through use of preventive services.	<ul style="list-style-type: none"> • Objective 1: Increase number of enrollees receiving preventive care to meet or exceed the NCQA Quality Compass National Medicaid Average. • Objective 2: Increase number of enrollees attending well and preventive visits to meet or exceed the NCQA Quality Compass National Medicaid Average. • Objective 3: Increase usage of timely maternal and child health services.
	Goal 2: Reduce burden of chronic disease.	<ul style="list-style-type: none"> • Objective 1: Increase number of enrollees receiving treatment for respiratory conditions to meet or exceed the NCQA Quality Compass National Medicaid Average. • Objective 2: Increase number of enrollees receiving diabetes care to meet or exceed the NCQA Quality Compass National Medicaid Average. • Objective 3: Increase number of enrollees receiving treatment for hypertension to meet or exceed the NCQA Quality Compass National Medicaid Average.
	Goal 3: Improve behavioral health outcomes.	<ul style="list-style-type: none"> • Objective 1: Increase number of enrollees receiving follow-up care after behavioral health treatment to meet or exceed the NCQA Quality Compass National Medicaid Average. • Objective 2: Increase number of enrollees receiving behavioral health care and treatment.
	Goal 4: Reduce burden of the SUD.	<ul style="list-style-type: none"> • Objective 1: Increase number of enrollees receiving treatment for SUD to meet or exceed the NCQA Quality Compass National Medicaid Average. • Objective 2: Improve coordination of care for enrollees receiving the SUD treatment.
	Goal 5: Provide supports for whole-person wellness and empower individuals to self-manage their health.	<ul style="list-style-type: none"> • Objective 1: Increase number of enrollees receiving smoking cessation services to meet or exceed the NCQA Quality Compass National Medicaid Average. • Objective 2: Increase number of enrollees receiving weight management counseling to meet or exceed the NCQA Quality Compass National Medicaid Average.

Goal 1: Improve the Health and Wellness of the State’s Medicaid and WVCHIP Populations Through Use of Preventive Services.

Timely preventive care helps drive improvements in health outcomes and reduces future burdens on the health care system. For example, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides health care services for children under 21 who are enrolled in Medicaid and WVCHIP, and is key to ensuring West Virginia’s Medicaid population receives appropriate and timely preventive services.²² Since the EPSDT services have been historically

²² Medicaid.gov. [Early and Periodic Screening, Diagnostic, and Treatment](#). Accessed on February 15, 2024.

underutilized in the state, the BMS continues to implement interventions to improve access to and use of these services. Approximately 54% of children in the state receive Medicaid or WVCHIP coverage; therefore, increasing use of these services is vital to the state's health outcomes.²³

Additionally, many avoidable health conditions can be prevented by receiving timely immunizations during well-visits. Vaccination rates for adolescent Medicaid members decreased from 29.7% in 2020, to 24.5% in 2023,²⁴ emphasizing the importance of focusing on improving vaccination rates among West Virginia's Medicaid population.

Among West Virginia's Medicaid population, breast cancer screenings for ages 50-64 have decreased by 7.8% between 2019 and 2022.²⁵ Additionally, approximately 29% of West Virginia seniors had cancer during their lifetime.²⁶ BMS is committed to improving timely access to cancer screening services for its Medicaid population.

Lastly, the BMS aims to address maternal health by improving timely access to prenatal and postpartum care services. Medicaid pays for approximately half of the births in West Virginia, highlighting the importance of improving health outcomes for this population.

Goal 2: Reduce Burden of Chronic Disease.

The BMS seeks to address Goal 2 by focusing on some of the most pressing chronic conditions affecting Medicaid and WVCHIP members. West Virginia ranks second worst in the nation for disease risk factors and prevalence.²⁷ 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 2019-2021.²⁸ Among West Virginia Medicaid members aged 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%.²⁹ Furthermore, West Virginia has the second highest kidney disease mortality rate (21.07 deaths per 100,000 state residents) and the second highest percentage of adults with high blood pressure (43.4%) of all states.³⁰

As a result, the BMS has selected goals and objectives to specifically assess progress related to these chronic conditions. Additionally, the BMS requires the MCOs to implement disease management programs focused on chronic conditions such as asthma and chronic obstructive pulmonary disease. For example, one MCO provides one-on-one asthma education and a peak flow meter for its members. Another MCO offers scholarships to Camp Catch Your Breath, a summer camp for members between the ages of eight to 13 with asthma.

²³ WVCHIP. [WVCHIP Enrollment Report, April 2025](#).

²⁴ BMS enterprise data solution claims data received and paid between November 30, 2020, and November 30, 2023.

²⁵ Ibid.

²⁶ West Virginia Department of Health, Division of Health Promotion and Chronic Disease. [West Virginia Cancer Statistics](#). Accessed on February 15, 2024.

²⁷ [West Virginia ranked least healthy state in America](#).

²⁸ CDC. [National Diabetes Statistics Report](#). May 15, 2024. Accessed on February 15, 2024.

²⁹ BMS enterprise data solution claims data received and paid as of February 29, 2024.

³⁰ Ibid.

Goal 3: Improve Behavioral Health Outcomes.

Improving behavioral health outcomes among West Virginia's Medicaid and WVCHIP population is a focus for the BMS, as Medicaid shares a disproportionate cost for mental health services. According to the most recent data from the Kaiser Family Foundation (KFF), 34.3% of adults who experienced mental illness are covered by Medicaid, compared to 21.6% nationally.³¹ In West Virginia, 33.3% of all Medicaid members aged 18-64 had a diagnosis of mental illness in 2023.³² The BMS is committed to improving health outcomes for members experiencing behavioral health diagnoses by improving timely access to care and follow-up for this population.

Goal 4: Reduce Burden of the SUD.

The opioid epidemic continues to be a prevalent issue throughout the nation and in West Virginia. In 2021, more than 106,000 reported deaths in the United States were due to drug overdose, which is the highest on record.³³ Drug overdose deaths have increased in West Virginia from 36.3 deaths per 100,000 to 90.9 deaths per 100,000 between 2011 and 2021. Additionally, nearly 84% of fatal overdoses reported by the State between March 2021 and March 2022 included an opioid, and nearly 96% of those overdoses included a synthetic opioid, such as fentanyl, which can be deadlier than natural opioids.³⁴ Combatting the opioid epidemic in West Virginia remains a top priority for the State, and the BMS continues to explore avenues to accomplish this goal. The CDC reported that West Virginia saw a 4% decrease in overdose deaths since 2020.³⁵ While progress is being made, there are still significant challenges that require focused attention.

The BMS continues to prioritize efforts to address SUD prevention and treatment and will work collaboratively with MCOs to collect data and track performance on measures to assess the impact of SUD-related programs and interventions. The 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 combatting SUD.

Goal 5: Provide Support for Whole-Person Wellness and Empower Individuals to Self-Manage Their Health.

West Virginia's population continues to be challenged by lifestyle risk behaviors. Approximately 25.2% of West Virginians are current smokers, which is the highest reported rate in the nation.^{36,37} The state also leads the nation in adults with obesity at 41%.³⁸ The BMS aims to empower members to take an active role in managing their health and wellness by improving access to tools such as tobacco cessation programs, weight assessment and counseling, and nutritional guidance. Recognizing that lifestyle changes often take place at the community level, BMS has tasked the MCOs with prioritizing the collection and use of social determinants of health (SDoH) data. In

³¹ KFF. [5 Key Facts About Medicaid Coverage for Adults with Mental Illness](#). National Survey on Drug Use and Health 2023.

³² BMS enterprise data solution claims data received and paid as of February 29, 2024.

³³ KFF. [Mental Health in West Virginia Fact Sheet, Substance Use and Deaths](#). Accessed on February 15, 2024.

³⁴ West Virginia Office of Drug Control Policy (ODCP). [CDC: Fatal overdoses drop slightly in WV from March 2021-22](#). September 9, 2022. Accessed on February 15, 2024.

³⁵ CDC. [Provisional Drug Overdose Death Counts](#). Accessed on January 22, 2026.

³⁶ West Virginia Division of Tobacco Prevention. [Cessation](#). 2022. Accessed on February 15, 2024.

³⁷ CDC, Behavioral Risk Factor Surveillance System (BRFSS). [2022 BRFSS Survey Data and Documentation](#). December 2, 2023.

³⁸ CDC, BRFSS. [Adult Obesity Prevalence Maps](#). 2022. Accessed on February 15, 2024.



doing so, the BMS is targeting opportunities to improve available mechanisms for capturing health-related social needs data and providing closed-loop referrals.

In partnership with the MCOs and West Virginia stakeholders, the OQM selected quality measures to drive and measure progress toward these goals and objectives. [Appendix B](#) provides a detailed list of quality measures, thresholds, and performance targets to be achieved over a three-year period. Monitoring activities are further described in [Section 4](#) and include the EQRO Annual Technical Report (ATR) findings, compliance monitoring, and working with the MCOs on corrective action, as appropriate, to ensure a commitment to continuous quality improvement.

Section 4: Assessment

The BMS evaluates the quality of care delivered to members in the MHT and MHP managed care programs through multiple methods of assessment, including the following:

- **Quality and Appropriateness of Care:** The BMS has policies and procedures in place to ensure that all MHT and MHP members receive high quality care, including those with special health care needs. The BMS and the MCOs evaluate data by age, race, ethnicity, and primary language spoken to create plans to eliminate health disparities.
- **Performance Measurement:** The BMS requires the MCOs to collect and report measures from NCQA HEDIS[®], CAHPS[®] surveys, and the Adult and Child Core Set Measures.
- **EQOR:** The BMS contracts with an EQRO to conduct independent evaluations of MCO performance, in accordance with federal regulations.

These assessment activities, detailed in the following subsections, provide tools for the BMS to evaluate progress on the Managed Care Quality Strategy goals and objectives.

4.1 Evaluation of the Quality and Appropriateness of Care

The BMS established this Managed Care Quality Strategy to include assessing and improving the quality of health care and services furnished to the MHT and MHP members under the MCO contracts as required by [42 CFR §438.340](#) and [42 CFR §457.1240\(e\)](#).

4.1.1 Identification of Age, Race, Ethnicity, Language, Disability Status, and Special Health Care Needs (§438.340(B)(6), §438.208, and §438.340)

The BMS collects information on member race, ethnicity, and primary language during the initial determination of Medicaid and WVCHIP eligibility and provides this information to the MCOs as part of the enrollment file. The enrollment file also identifies individuals who have qualified for Medicaid because of their disability status. “Disability status” means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability³⁹ (i.e., Supplemental Security Income [SSI] beneficiaries). The MCOs collect updated information from members when conducting initial health risk assessments or at other touchpoints. The MCOs are contractually required to collect and meaningfully use member-identified race, ethnicity, language, and SDoH data to identify and reduce disparities in health care access, services, and outcomes. The MCO must consider information about SDoH as identified by bodies including, but not limited to, the CDC for care coordination services.

Medicaid and WVCHIP have mechanisms to identify persons with special health care needs, defined as individuals with complex or serious medical conditions who also require health and related services of a type or among beyond what is generally required. MCOs identify individuals with complex or serious medical conditions through the initial health assessment and their population health programs.

Following, we further describe how the BMS uses this data to assess progress on meeting the goals and objectives of this Managed Care Quality Strategy and the impact to identify measures.

4.1.2 Assessing Quality and Appropriateness of Care for Members with Special Health Care Needs

The BMS monitors regular reporting from the MCOs to assess quality of care provided to members with special health care needs. Quarterly reporting on metrics such as utilization, claims, grievance

³⁹ For purposes of 42 CFR §438.340(b)(6) (applicable also to CHIP managed care programs per 42 CFR §457.1240(e)), “disability status” means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability.

and appeals, access, and networks are broken out by eligibility category so that members who have coverage based on SSI disability can be analyzed separately.

Each MCO's QAPI must include mechanisms to detect both underutilization and overutilization of services and to assess the quality and appropriateness of care provided to members with special health care needs. The MCOs must use appropriate health care professionals in assessing those conditions, identifying medical procedures to address and/or monitor the conditions, and developing treatment plans appropriate for those members determined to need a course of treatment or regular care monitoring.

The QIA Council collects and analyzes data necessary to monitor quality indicators and to provide evidence related to the CMS assurances and sub-assurances. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, people/family focus groups and interviews, and other stakeholder feedback and input.

4.1.3 West Virginia Health Outcomes Plan

The BMS is committed to reducing health disparities that exist across the Medicaid and WVCHIP populations. The State analyzes data across age, sex, ethnicity, race, and disability status to identify disparities and design quality improvement interventions. To this end, the BMS has incorporated robust provisions in the MHT and MHP managed care contracts to address health disparities. The MCOs are required to hire a SDoH director as part of their key staff. They must also establish a SDoH Committee to monitor and improve population health outcomes, including addressing SDoH to assess overall health plan performance. This Committee is chaired by the MCO's Health SDoH director and involves members, network providers, and stakeholders, as appropriate. Activities include developing strategies to address SDoH and improving their ability to collect and use data to reduce disparities in health care access, services, and outcomes.

The MCOs must maintain accreditation from NCQA for their Medicaid and WVCHIP lines of business. In the event the MCO is not accredited, for example, due to merger or acquisition, the MCO must adhere to NCQA standards. To facilitate delivering outcomes-driven health services, BMS requires MCOs to adopt strategies to simplify administrative procedures, per the NCQA Health Equity Accreditation or Health Equity Accreditation Plus programs.

4.2 Performance Measurement

4.2.1 National Performance Measures

Performance measurement is key to monitoring and improving quality. To the extent possible, The 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. Specifically, the MCOs must collect and report measures in the following areas:

- Screening and preventive care.
- Chronic care.
- Access, availability, and timeliness of care.
- Utilization.
- Member satisfaction measures.

If the CMS or NCQA adopts additional performance measures, the BMS will incorporate them into the Managed Care Quality Strategy. Requirements for MCO performance measures and levels are contained in the MCO contracts. The BMS selected measures for the Managed Care Quality Strategy primarily from these data sets. National measures with defined technical specifications ensure consistency in reporting and allow West Virginia to benchmark performance against other Medicaid and CHIP programs.

4.2.2 MCO Reporting

The MCOs are required to submit monthly, quarterly, annual, and ad-hoc reports as described in the program’s respective MCO contracts. The BMS reviews reporting to monitor the MCO operations and performance on an ongoing basis. This monitoring enables the BMS to identify potential issues in a timely manner and work with the MCO to resolve. For example, a number of MCO reports give the BMS insight into changes in network or primary care provider (PCP) panel sizes that could affect members’ access to care. The BMS monitors fraud, waste, and abuse activities, claims, and high priority mental health and SUD services on a monthly basis. Quarterly reporting provides insight into MCO operations, networks, membership, and utilization. As part of the annual review of the Managed Care Quality Strategy, BMS reviews the MCO QAPI plans.

4.3 EQR Activities and Process

The BMS contracts with an EQRO⁴⁰ to conduct annual, external, independent reviews of the timeliness of, access to, and quality outcomes related to the services covered under each MCO contract in compliance with [42 CFR §438.340](#), [42 CFR §438.350](#), and [42 CFR §457.1250](#). The EQRO performs four required and three optional EQR activities in accordance with the CMS EQR protocols. *Table 2* summarizes the EQR activities performed.

Table 2: EQR Activities

Required Reporting	Optional Activities
<ol style="list-style-type: none"> 1. Systems Performance Review. 2. Performance Measure Validation. 3. PIPs. 4. Network Adequacy Validation. 	<ol style="list-style-type: none"> 1. 24/7 Access to Care Standard Evaluation. 2. Encounter Data Validation. 3. Grievance/Appeals/Denials Review.

The EQRO produces a CMS-mandated Annual Technical Report (ATR) that summarizes results from all of the EQR activities and includes:⁴¹

- Results of the EQR-related activities.
- EQRO’s assessment of each MCO’s strengths and weaknesses related to quality, timeliness, and access.
- Recommendations for improving the quality of health care services furnished by each MCO and recommendations for how the State can target goals and objectives in the Managed Care Quality Strategy.
- Methodologically appropriate, comparative information about all of the MCOs.
- Assessment of the degree to which each MCO has addressed the recommendations for quality improvement made by the EQRO during the previous year’s EQR.

⁴⁰ BMS is contracted with Qlarant to perform EQRO activities.

⁴¹ Medicaid.gov. [Quality of Care External Quality Review](#) (n.d.). Accessed on March 1, 2024.

The EQR activities provide assurance and confidence that MCO-reported data is accurate and comprehensive. The BMS relies on the findings to identify areas for improvement, track progress on Managed Care Quality Strategy goals, and define future areas of focus. The BMS works closely with the EQRO to select the strategy's objectives and performance measures. The [West Virginia ATRs](#) are published on the BMS website. The EQR activities overlay the monitoring and quality improvement activities performed by the BMS.

4.3.1 Non-Duplication of Standards (§438.360 and §457.1250)

The CMS “non-duplication” regulation gives states the authority to use information obtained from a private accreditation review source, such as the NCQA, to demonstrate compliance with the State’s EQR operational review standards. States can deem private accreditation organization standards as equivalent to state standards to prevent the duplication of mandatory compliance reviews.

Currently, the CMS supports the non-duplication approach for one or more of the three mandatory EQR-related activities: the PIPs, validation of performance measures, and review of compliance with Medicaid managed care regulations. To do so, the following conditions must be met:

1. The MCO is in compliance with the applicable Medicare Advantage or private accreditation standards.
2. The Medicare or private accreditation review standards are comparable to those established through the EQR protocols for the three mandatory EQR-related activities.
3. The MCO provides the State with all applicable reports, findings, and other results of the Medicare or private accreditation review applicable to the specified EQR-related activities.

The BMS requires participating MCOs to seek and maintain the NCQA accreditation. The EQRO reviews the Medicare, Medicaid, and CHIP standards for instances where structural and operational standards overlap. Such areas for overlap may include credentialing and re-credentialing procedures, using practice guidelines, reporting processes to the MCO Board of Directors, and approval of the Quality Improvement Committee. In cases where the state or federal standard is less stringent than the NCQA requirement, BMS can use NCQA’s assessment in place of the EQR compliance review.

Deemable elements for non-duplication are provided in [Appendix F](#).

Section 5. Federal and State Standards

The BMS regularly assesses the MCO compliance with federal and state quality standards, including those outlined in 42 CFR [Subpart D](#) and 42 CFR [Subpart L](#). Monitoring compliance with these standards is key as they establish an infrastructure to promote high quality, accessible care. The BMS employs prospective, concurrent, and retrospective methods to ensure compliance with managed care quality standards, detailed in [Table 3](#).

Table 3: Methods for Determining Compliance with Federal and State Quality Standards

Method Type	Compliance Monitoring Activities
Prospective Methods	<ul style="list-style-type: none"> • The MCO certification. • The MCO contracts with the state of West Virginia. • Review of the MCO provider network. • West Virginia State Insurance Commission MCO licensing.
Concurrent Methods	<ul style="list-style-type: none"> • Review of the MCO quarterly operational reports and encounter data. • Monitoring of enrollment broker activities, including disenrollment.
Retrospective Methods	<ul style="list-style-type: none"> • Annual external review, including compliance review, validation of performance measurements, validation of PIPs, network validation, encounter data validation, 24/7 access standard evaluation, and review of grievance/appeals/denial data. • Review of the NCQA HEDIS® and CAHPS® results. • Review of the MCO annual reporting.

The BMS uses these monitoring activities to determine whether the MCOs meet the minimum required standards of the MHT or MHP programs, commensurate with state and federal laws and regulations. The MCO contracts for each program describe minimum standards and are compliant with all of the current Medicaid and CHIP managed care regulations.

5.1 Current and Future Federal and State Standard Updates

5.1.1 CMS Final Rules

The CMS published key Final Rules for Medicaid and WVCHIP regulations in 2016, with subsequent regulation updates in 2017, 2020, and 2024. In 2024, CMS released the Medicaid and CHIP Managed Care Access, Finance and Quality Final Rule (CMS-2439-F). The purpose of the Final Rule is to advance the CMS’ efforts to improve access to care and quality and health outcomes for Medicaid and CHIP managed care enrollees. The Final Rule included regulatory updates aimed at improving Medicaid and CHIP programs, affecting network adequacy, state directed payments, medical loss ratio, and quality rating for managed care plans.

In addition to CMS 2439-F, the CMS released the Ensuring Access to Medicaid Services Final Rule (CMS-2442-F), which aims to increase care, quality, and health outcomes. One of the components of this rule requires states to ensure public transparency by amending procedural and operational requirements of Medical Care Advisory Committees, as well as establish a BAC. These councils are described in additional detail in Section 1.2.

Final Rule compliance timeframes vary significantly by rule and applicability date. Several regulation requirements span into 2030. BMS will continue to review and ensure compliance with all final rules, adapting this Managed Care Quality Strategy over time to meet requirements and regulations set forth by the CMS.

5.1.2 One Big Beautiful Bill Act (OBBBA)

Key federal policy shifts have impacted aspects of Medicaid including funding and eligibility criteria, with potential effects on quality oversight. In July 2025, the budget reconciliation act H.R.1 was passed into law, with several key provisions related to Medicaid, including:

- Mandatory six-month redetermination and community engagement for select populations.
- Stricter rules on health care-related provider taxes and state directed payment policies.
- Elimination of ACA subsidy eligibility for certain lawfully present immigrants.
- Discontinued conditional eligibility for ACA subsidies, as well as passive re-enrollment.
- Required compliance with community engagement and work policies.

Analyses of these policies predict the disenrollment of roughly 54,000 Medicaid enrollees in West Virginia and potential funding shortfalls due to the decreases in provider taxes.⁴² Budget constraints will underscore the need for quality monitoring and value-based care initiatives to ensure financial sustainability of the state’s managed care programs and optimize reimbursement. Additionally, reductions in enrollment due to loss of eligibility or churn may complicate quality tracking by distorting denominators in quality measures.

The BMS will continue to monitor the impact of H.R.1, as many provisions will not go into effect immediately.

5.1.3 West Virginia Four Pillars of Health

In March 2025, West Virginia Governor Patrick Morrisey announced a series of statewide initiatives to improve the health of West Virginia, in alignment with the health priorities of the federal administration. These initiatives all aim to support Governor Morrisey’s “Four Pillars of a Healthy West Virginia: ⁴³”

1. Clean Up the Food.
2. Find Purpose, Find Health.
3. Move Your Body, Change Your Life.
4. Reward Healthy Choices.

The BMS is committed to supporting the health of West Virginia Medicaid members through interventions that align with this framework:

- The BMS has supported MCO-developed programs to provide fresh, healthy food to members as well as improving food access.
- Under the provisions of the OBBBA, the BMS will implement a community engagement requirement for Medicaid expansion adults.
- The BMS has approved several MCO value-added services that promote physical activity and exercise among members, including healthy weight programs and gym memberships.
- One West Virginia MCO operates a value-added service wherein members receive a \$25 gift card for completing a walking program.

⁴² KFF. [How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?](#)

⁴³ West Virginia Office of the Governor. [Governor Morrisey Announces Transformational Opportunity to Improve Rural Healthcare Outcomes and Increase Standard of Living.](#)

The BMS intends to continue this commitment to empowering members in their individual health in future iterations of the Managed Care Quality Strategy.

5.2 Access and Availability Standards

5.2.1 Availability of Services (§438.206 and §457.1230)

Through its MCO contracts, BMS requires all applicable services covered under the [Medicaid State Plan](#) and [WVCHIP State Plan](#) be available and accessible to managed care members. The MCOs provide to members, directly or through arrangements with subcontractors, all covered services described in the MCO contract. The MCOs are required to coordinate with State Plan services covered under FFS, including pharmacy and NEMT services, and ensure that members can access these services.

The MCOs are required to submit quarterly assurance of adequacy through a PCP panel and specialist availability report. On an annual basis, the BMS requires MCOs to submit their full provider network analysis for re-evaluation. The BMS measures the networks by comparing against established network adequacy standards.

5.2.2 Network Adequacy Standards (§438.68 and §457.1218)

The BMS requires MCOs to maintain provider networks in geographically accessible locations and sufficient numbers to provide all covered services in a timely manner. Network standards can be found in the MHT and MHP [contracts](#), Appendix I and J, respectively.

Network standards include provider-to-enrollee ratios and travel time and distance requirements. The provider-to-enrollee ratios ensure that the MCO provider networks have adequate capacity while the travel time and distance standards establish choice and geographic accessibility of providers. Standards vary based on population and provider type to ensure medical services are accessible throughout the state.

To meet access requirements, the MCOs must meet the defined provider-to-enrollee ratios and time and distance standards in every county. In calculating provider-to-enrollee ratios, the MCOs may only count unique providers located within the county. For the time and travel standard, the MCOs may count all provider locations within the county or within the appropriate travel time from the county border.

In accordance with [42 CFR §438.206\(c\)\(iii\)](#), when medically necessary, the MCO must make services available 24 hours a day, seven days a week, and establish a mechanism to ensure that providers comply with the access standards set forth in the MCO contract. The MCOs must regularly measure the extent to which network providers comply with these requirements and take remedial action if necessary. BMS also contracts with the EQRO to perform an audit of the MCO compliance with access to care.

West Virginia faces unique obstacles, including significant professional workforce shortages,^{44,45} 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.⁴⁶ The BMS will consider requests

⁴⁴ West Virginia University. [Medical Personnel Shortage in West Virginia](#). Jordan Dennison. October 31, 2024.

⁴⁵ KFF. [Primary Care Health Professional Shortage Areas \(HPSAs\)](#). December 31, 2024.

⁴⁶ 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.

for exceptions to the provider access standards under limited circumstances (e.g., if no appropriate provider types are located within the mileage standards) and may, in its sole discretion, grant exceptions to these standards. Each exception request from the MCO to BMS must be in writing and supported by information and documentation from the MCO. Exceptions to network requirements will be considered based on the information provided, current patterns of care, and locations where the travel time and distance standards differ significantly from providers in the community, as allowed in West Virginia's 1915(b) Waiver.

The 2024 CMS Managed Care Final Rule (CMS-2439-F) includes provisions related to provider network adequacy, including, but not limited to:

- Establish national maximum appointment wait time of 15 business days for routine primary care and obstetric/gynecological, and 10 business days for routine outpatient behavioral health and SUD services. In addition, a state-selected standard chosen in an evidence-based manner by the state Medicaid agency within state-established timeframes will be developed in calendar year (CY) 2026.
- Require secret shopper surveys as part of monitoring activities, using independent entities.
- Require an annual enrollee experience survey.

These updated regulations seek to improve access to care and ensure quality through enhanced monitoring.

5.2.3 Assurances of Adequate Capacity and Services (§438.207 and §457.1230)

The MCOs must establish and maintain provider networks that have the capacity to provide all covered services to its membership. These networks must be comprised of hospitals, PCPs, dental, and specialty care providers with sufficient numbers to make available all covered services in adequate amount, duration, and scope to reasonably achieve its purpose. In accordance with [42 CFR §438.207](#), the MCOs must maintain a sufficient number, mix, and geographic distribution of providers.

5.2.4 Coordination and Continuity of Care (§438.208 and §457.1216)

The BMS requires the MCOs to provide an integrated approach to coordination and continuity of care, including procedures to deliver primary care to and coordinate health care service for all the MCO members. The MCOs must ensure that each member has an ongoing source of primary care. In addition to coordination of covered services, the MCOs are required to have programs that include coordination with social and community services to address members' whole needs. The BMS details continuity of care requirements in the MCO contract.

5.2.5 Transition of Care Policy (§438.62 and §457.1216)

The BMS requires that each MCO has a transition of care policy that minimizes gaps in services and streamlines transitions for members. The MCOs must have a transition of care policy to ensure continued access to services during a transition to or from FFS to an MCO, transition from one MCO to another, or between settings of care when members, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. Each MCO's transition of care policy must, at a minimum, meet the BMS and WVCHIP defined transition of care policy and comply with federal requirements as specified in [42 CFR §438.62\(b\)](#) and [42 CFR §457.1216](#). Each MCO's transition of care policy must ensure compliance with [42](#)

CFR §438.62(b)(1)(vi) regarding the process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR §170.213.

5.2.6 Coverage and Authorization of Services (§438.210 and §457.1230)

The BMS ensures that each MCO complies with the requirements regarding coverage and authorization of services. The MCO contracts identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer.

5.3 Structure and Operation Standards

5.3.1 Sub Contractual Relationships and Delegation (§438.230 and §457.1233)

With the BMS approval, the MCOs may enter into subcontracts for the provision of covered services to managed care members. The BMS ensures through their contracts that each MCO complies with requirements regarding sub-contractual relationships and delegation.

5.3.2 Provider Contracting (§438.214 and §457.1233)

The BMS requires through their contracts that each MCO implements written policies and procedures for selection and retention of providers. In compliance with state and federal regulations, the BMS established a uniform credentialing and re-credentialing policy that each MCO must follow. The MCO contracts contain detailed MCO credentialing requirements.

5.3.3 Enrollment and Disenrollment (§438.54, §457.56, §457.1210, and §457.1212)

The BMS requires through their contracts that each MCO complies with the enrollment and disenrollment requirements and limitations.

5.3.4 Enrollee Information (§438.10 and §457.1207)

The BMS requires that MCOs inform enrollees of the services, operations, and rights under the MHT and MHP programs. The MCO contracts contain requirements for member information as specified in 42 CFR §438.10 and 42 CFR §457.1207.

5.3.5 Confidentiality (§438.224 and §457.1110)

The BMS requires through their contracts that each MCO uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR Parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable. The MCO contracts contain requirements that are consistent with 42 CFR Part 431 Subpart F.

5.3.6 Grievance and Appeals Systems (§438.228, §438 Subpart F, and §457.1260)

The BMS requires that each MCO has in effect a grievance system that meets the requirements of 42 CFR §438.228, 42 CFR §438 Subpart F, and 42 CFR §457.1260. Detailed MCO grievance requirements are contained in the MCO contracts. The State requires MCOs to maintain records of grievances and appeals and reviews this information through the MCO quarterly reporting process. The State and EQRO collect and review quarterly grievances, denials, and appeals information from the MCOs. They conduct annual audits of the grievances and appeals reports and MCO processes to ensure compliance with regulations and timeframes.

The BMS delegates responsibility for notice of action to the MCO under 42 CFR §431 Subpart E of this chapter. The BMS, or its contractor, reviews or audits each delegated MCO and its providers and subcontractors to ensure that they are notifying members and providers in a timely manner.

5.4 Health Information Systems and Information Technology (§438.242 and §457.1233(d))

A strong health information technology infrastructure drives quality improvement by enabling continuous quality monitoring, assessment, and improvement activities. The BMS is committed to investing in information systems that support Medicaid and WVCHIP operations. The State maintains an eligibility and a claims processing system (Medicaid Management Information System [MMIS]) and a managed care enrollment system.

5.4.1 Eligibility System

West Virginia is in the process of transitioning from its legacy eligibility system, the Recipient Automated Payment and Information Data System, to an integrated eligibility system, West Virginia People's Access to Help (WV PATH). West Virginia DoHS programs supported by the WV PATH system include Medicaid, WVCHIP, the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families (TANF or WV WORKS), and other State-operated assistance programs.

5.4.2 MMIS

MMIS is a shared resource between the BMS and the West Virginia Departments of Health, Health Facilities, Human Services, and the Office of Shared Administration's Office of Management Information Services (MIS). MMIS processes the FFS claims and capitation payments and collects encounter data submitted by the MCOs. The FFS claims include those services carved out of the managed care delivery system, such as pharmacy and NEMT services, and excluded from the MCO capitation rates. The encounter data is used in the managed care rate setting process.

5.4.3 Managed Care Enrollment Information System

The contracted enrollment broker maintains the managed care enrollment information system, which is linked to the MMIS. This system includes information on past and current MHT or MHP enrolled members, including historical MCO assignments, whether individual enrollment in an MCO was voluntary or assigned, and PCP assignments. The enrollment system tracks reasons for disenrollment and member MCO switches. This system also includes information on provider networks so that the enrollment broker can assist members in selecting a PCP.

5.4.4 Medicaid Enterprise Data Solution (EDS)

The BMS and MIS utilize the EDS, which includes MCO and FFS encounter and eligibility information along with provider information to support reporting, data mining, and program analyses. The EDS replaced the previous Data Warehouse/Decision Support System, with its various components transitioning over several months in early 2022. The OQM utilizes the EDS for some reporting of the Adult, Child, and Health Homes Core Sets of Quality Measures (Core Sets) as well as additional HEDIS[®] measures outside of the Core Sets. The HEDIS[®] measures included in the EDS pre-built components are NCQA-certified. There are additional data sources, as well as planned data sources, that feed into the EDS for the use of OQM and MIS representatives. Additional measures that are not HEDIS[®] may be included in the pre-built components but not necessarily certified by the measure steward(s).

5.4.5 MCO Information Systems

The BMS requires that each MCO maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of [42 CFR §438.242](#) and [§457.1233\(d\)](#). The system must provide information on areas including, but not limited to, utilization, grievances, appeals, and denials and disenrollment for reasons other than loss of eligibility. The MCOs must submit monthly encounter data for all defined benefit package services no later than 90 calendar days after the end of the quarter in which the encounters occurred. The BMS reviews all encounter

data for timeliness and usability and performs longitudinal analysis to make sure the data is complete and accurate.

5.5 Intermediate Sanctions

The MCO contracts establish intermediate sanctions under certain circumstances as required by 42 CFR §438.700 and 42 CFR §457.1270. The MCOs are allowed due process protections, including a notice of sanction (42 CFR §438.710). The managed care contracts inform the MCOs that the BMS must notify the CMS of any sanctions imposed (42 CFR §438.724). In addition, the BMS retains authority to impose additional sanctions at its discretion under state statutes or state regulations (42 CFR §438.702(b)). The BMS exercises this authority by monitoring the following key dimensions to determine areas of the potential non-performance:

- Member enrollment and disenrollment.
- Provision of coverage and benefits.
- Operational requirements.
- Quality assurance, data, and reporting.
- Payment provisions.
- Subcontractor oversight.
- Other business terms.

If an MCO does not meet the terms and conditions established in the contract, the BMS has the authority to require corrective action plans (CAPs), impose liquidated damages and other financial penalties, suspend new enrollments, and fail to renew or terminate the contract.

5.6 Measurement and Improvement Standards

5.6.1 Clinical Practice Guidelines (§438.236 and §457.1233(c))

The BMS requires, through their Medicaid managed care contracts, that each MCO complies with requirements regarding practice guidelines. However, the BMS does not require MCOs to adopt a specific set of clinical practice guidelines. Instead, the BMS requires the MCOs to adopt and disseminate evidence-based practice guidelines which must be based on valid and reliable medical evidence or a consensus of healthcare professionals in the field. Additionally, guidelines should consider the needs of the enrolled population and be adopted in consultation with contracting health care professionals and must be reviewed and updated periodically.

5.6.2 QAPI Program (§438.330 and §457.1240)

The BMS ensures that each MCO has an ongoing QAPI program for the services it furnishes to its members. Detailed MCO quality assessment and performance improvement requirements are contained in the MCO contract.

If the CMS, in consultation with states and other stakeholders, directs states to implement new performance measures and/or topics for performance improvement, the BMS will incorporate these performance measures and topics into the QAPI program requirements.

At least annually, BMS reviews the impact and effectiveness of each MCO's QAPI program. The review includes the MCO's performance on the reported standard measures and the results of each MCO's PIP. The MCOs are required to have a process for their own evaluation of the impact and effectiveness of their QAPIs.

Section 6: Improvement and Interventions

The BMS is committed to improving quality of care by supporting the MCO initiatives, incentivizing providers, and implementing targeted interventions. The MCOs are required to offer disease and care management programs and regularly undertake targeted improvement initiatives. In recent years, the BMS has increased its efforts to engage providers in more value-driven payment arrangements at both the MCO and individual provider level. The BMS will work with the MCOs to ensure the following interventions address the goals and required measures throughout the period of this Managed Care Quality Strategy. These interventions will also provide the BMS with quality-related data for future monitoring and planning.

6.1 Improving Quality of Care through Interventions

6.1.1 PIPs (§438.330)

Each MCO must conduct annual PIPs designed to make improvements in specific areas of concern. PIPs must be:

- Designed to achieve significant improvement through ongoing measurements and intervention.
- Sustained over time.
- In clinical care and non-clinical care areas that have a favorable effect on health outcomes and enrollee satisfaction.

The MCOs must initiate and maintain at least three PIPs at a time. At least one PIP must be for a clinical focus area that impacts pediatric members. The topics must be identified through continuous data collection and analysis, systematically selected and prioritized to achieve the greatest practical benefit for members, and reflect the prevalence of a condition among, or need for a specific service by, the MCO’s members based on enrollee demographic characteristics, health risks, and any other special needs. The BMS, in consultation with the EQRO, determines topics for two of the current PIPs based on MCO performance (see *Table 4-7*). This does not restrict the MCO from conducting other PIPs as they determine necessary for the health and wellness of their specific enrollment population. The BMS EQRO validates PIPs to ensure they were designed, conducted, and reported in a methodologically sound manner and meet all state and federal requirements.

Table 4: MHT State-Mandated PIPs

MHT State-Mandated PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
Annual Dental Visits (retired on December 31, 2023, replaced with Lead Screening in Children)	PM 1: Annual dental visits for children 2-3 years of age. Measure Steward: NCQA Population: Children 2-3 years of age. PM 2: Percentage of eligible members that	Will implementation of targeted member/provider/MCO interventions improve rates of annual dental visits for members 2-3 years of age and eligible members receiving preventive dental services for members 1-20 years of	<ul style="list-style-type: none"> • Member incentive. Provided members with a \$25 gift card for completing a dental visit. • No cost transportation. Promoted member no cost transportation services via member outreach; gaps in care and case management calls; and member handbook, newsletters, and website.

MHT State-Mandated PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
	<p>received preventive dental services.</p> <p>Measure Steward: Formerly CMS*</p> <p>Population: Children, adolescents, and adults 1-20 years of age.</p>	<p>age each measurement year?</p>	<ul style="list-style-type: none"> • Gaps in care education. Conducted educational provider webinars, which explained why members have gaps in care and provided education on how to close the gaps, including appropriate dental coding. Education included provider best practice descriptions. • Provider incentive. Incentivized providers to complete well-child visits and encouraged them to discuss dental care and benefits during these visits. • Children’s wellness club. Offered exclusive opportunities to members 13 years of age and under to earn prizes by participating in a variety of wellness activities, including oral health and dental care.
<p>Lead Screening in Children</p>	<p>PM 1: Lead Screening in Children.</p> <p>Measure steward: NCQA</p> <p>Population: Children two years of age.</p> <p>PMs 2 and 3: Well-Child Visits in the First 30 Months of Life:</p> <ul style="list-style-type: none"> • 0-15 months. • 15-30 months. <p>Measure steward: NCQA</p> <p>Population: Children through 30 months of age (Medicaid and CHIP).</p>	<p>Will implementation of targeted member, provider, and MCO interventions improve rates of lead screening in members two years of age and well-child visits for members through 30 months of age each measurement year?</p>	<ul style="list-style-type: none"> • MCO Lead Screening in Children PIP submissions for 2024 were baseline submissions and did not require interventions.
<p>Follow-Up After Emergency Department Visit for Mental Illness</p>	<p>PM 1: Follow-up after emergency department visit for mental illness – 30-day follow-up (total).</p> <p>Measure Steward: NCQA</p>	<p>Will implementation of targeted member/provider/MCO interventions improve 30-day follow-up visit rates for members six years of age and older who had an emergency department visit with a</p>	<ul style="list-style-type: none"> • Measure year (MY) 2022 served as the baseline year for this PIP. Implementation of interventions is not required until after the baseline year. The MCOs identified member, provider, and MCO barriers and began implementing interventions targeting barriers during 2023. These

MHT State-Mandated PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
	Population: Children, adolescents, and adults six years of age and older.	principal diagnosis of mental illness or intentional self-harm each measurement year?	interventions will be evaluated and reported in the next annual report.

*Summarized list of MCO interventions.

Table 5: MHT MCO-Selected PIPs

MHT MCO-Selected PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
Care for Adolescents (MCO 1)	<p>PM 1: Immunizations for Adolescents – Combination 2.</p> <p>Measure Steward: NCQA</p> <p>Population: Adolescents 13 years of age.</p> <p>PMs 2 and 3: Child and adolescent well-care visits:</p> <ul style="list-style-type: none"> ● 12-17 years of age. ● 18-21 years of age. <p>Measure Steward: NCQA</p> <p>Population: Adolescents and adults 12-21 years of age.</p>	Will the implementation of member, provider, and MCO interventions increase the rates of adolescent care, including well-visits and immunizations received amongst members 9-21 years of age enrolled in MHP, by the end of the measurement year?	<ul style="list-style-type: none"> ● Member incentives. Awarded members 12-18 years of age a \$25 gift card for completing an annual well-child visit. ● Targeted outreach. Contacted members enrolled in case management to encourage well-child visits and offered assistance in scheduling appointments. ● No cost transportation. Promoted member no cost transportation services via member outreach; gaps in care and case management calls; and member handbook, newsletters, and website. ● Provider incentive. Incentivized providers with \$25 for completing and closing their gaps in well-child visits. ● HEDIS® provider toolkit. Provided provider office staff with HEDIS® measure education, including well-child and immunization-related measures, medical record documentation tips, and coding requirements.
Promoting Health and Wellness in Children and Adolescents (MCO 2)	<p>PM 1: Child and adolescent well-care visits – total.</p> <p>Measure Steward: NCQA</p> <p>Population: Children, adolescents, and adults 3-21 years of age.</p>	Will member, provider, and MCO interventions focusing on improving children and adolescents' well-being increase rates for the Child and Adolescent Well Care Visits measure and	<ul style="list-style-type: none"> ● Member education. Contacted member parents/guardians via telephone or postcard and educated them on the importance of well-care visits, COVID-19 safety protocols, and the availability of telehealth services. Information was also communicated through social

MHT MCO-Selected PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
	<p>PMs 2 and 3: Weight assessment and counseling for nutrition and physical activity for children/adolescents:</p> <ul style="list-style-type: none"> ● Body Mass Index (BMI) percentile documentation. ● Counseling for nutrition. <p>Measure Steward: NCQA</p> <p>Population: Children and adolescents 3-17 years of age.</p>	<p>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents BMI and Counseling for Nutrition measures by 10 percentage points over the life of the PIP?</p>	<p>media posts, the MCO websites, and the member handbook.</p> <ul style="list-style-type: none"> ● Member incentive. Awarded members who completed an adolescent well-care visit a \$25 gift card. ● Provider gap in care reports. Identified members in need of an annual well-care visit and distributed gap in care reports to PCPs, federally qualified health centers, and rural health clinics. ● Alternate payment model agreement. Continued an alternate payment agreement with select providers, which included well-care visits as a targeted area for improvement. ● Transportation notice. Informed members/parents/guardians of the availability of transportation to care during welcome calls.
<p>Immunizations for Adolescents (MCO 3)</p>	<p>PMs 1 and 2: Immunizations for Adolescents:</p> <ul style="list-style-type: none"> ● Combination 2. ● Human Papillomaviruses (HPV). <p>Measure Steward: NCQA</p> <p>Population: Adolescents 13 years of age.</p>	<p>Will implementation of member, provider, and MCO interventions increase rates for Immunizations for Adolescents Combination 2 and HPV over the life of the PIP?</p>	<ul style="list-style-type: none"> ● Member education. Texted messages to members, which aimed to educate using evidence-based guidelines and describe immunization purpose, safety, and efficacy. Conducted calls to members and mailed EPSDT birthday reminders to encourage members to obtain preventive care and vaccinations. ● Member incentive. Provided a \$50 gift card to members who completed the HPV vaccine series on or before their 13th birthday. ● Provider quality incentive program (expansion). Expanded an incentive-based program to additional provider groups and included the Immunizations for Adolescents – Combination 2 measure as a key metric. ● Pay for quality. Incentivized providers to close gaps in care for members receiving one tetanus, diphtheria toxoids, and acellular pertussis vaccine, one meningococcal vaccine, and HPV

MHT MCO-Selected PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
			<p>on or before their 13th birthday (\$50 per gap closure).</p> <ul style="list-style-type: none"> ● Provider action plans. Worked with large primary care groups to develop action plans, interventions, and goals to improve vaccination rates. Gap in care reports are also distributed to the top 10 providers with the largest gaps in care. Clinical quality auditors work with providers to improve performance.

*Summarized list of MCO interventions.

Table 6: MHP State-Mandated PIPs

MHP State-Mandated PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
<p>Annual Dental Visit (retired on December 31, 2023; replaced with Lead Screening in Children)</p>	<p>PM 1: Annual dental visits for 2-3 years of age. Measure Steward: NCQA Population: Children 2-3 years of age.</p> <p>PM 2: Percentage of eligible members that received preventive dental services. Measure Steward: CMS Population: Children, adolescents, and adults 1-20 years of age.</p>	<p>Will the implementation of collaborative member, provider, and MCO interventions improve Annual Dental Visit rates among children 2-3 of age and preventive dental services rates among children 1-20 years of age enrolled in the MHP program by the end of the measurement year?</p>	<ul style="list-style-type: none"> ● No cost transportation. The MCO promoted member no cost transportation services during member outreach; gaps in care and case management calls; and member newsletters, member website, and member handbook. ● Children’s wellness club. Members 13 years of age and under were offered exclusive opportunities to earn prizes by participating in a variety of wellness activities, including oral health and dental care. ● Member incentive. Members 12-18 years of age received a \$25 gift card for completing an annual well-child visit. Members 2-3 years of age received a \$25 gift card for completing an annual dental visit. ● Provider incentive. Providers were incentivized to complete well-child visits for members 12-17 years of age and encouraged to discuss dental care and dental benefits during these visits. ● Gaps in care education. The MCO delivered Gaps in Care

MHP State-Mandated PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
			Lunch and Learn webinars, which described best practices and why members have gaps in care, and provided education on how to close the gaps, including appropriate dental coding.
Lead Screening in Children	<p>PM 1: Lead Screening in Children.</p> <p>Measure steward: NCQA</p> <p>Population: Children two years of age.</p> <p>PMs 2 and 3: Well-Child Visits in the First 30 Months of Life:</p> <ul style="list-style-type: none"> 0-15 months. 15-30 months. <p>Measure steward: NCQA</p> <p>Population: Children through 30 months of age (Medicaid and CHIP).</p>	Will implementation of targeted member, provider, and MCO interventions improve rates of lead screening in members two years of age and well-child visits for members through 30 months of age each measurement year?	<ul style="list-style-type: none"> MCO Lead Screening in Children PIP submissions for 2024 were baseline submissions and did not require interventions.
Care for Adolescents	<p>PM 1: Immunizations for Adolescents – Combination 2.</p> <p>Measure Steward: NCQA</p> <p>Population: Adolescents 13 years of age.</p> <p>PMs 2 and 3: Child and adolescent well-care visits:</p> <ul style="list-style-type: none"> 12-17 years of age. 18-21 years of age. <p>Measure Steward: NCQA</p> <p>Population: Adolescents and</p>	Will the implementation of member, provider, and MCO interventions increase the rates of adolescent care, including well-visits and immunizations received amongst members 9-21 years of age with Aetna Better Health of West Virginia MHP by the end of the measurement year?	<ul style="list-style-type: none"> No cost transportation. The MCO promoted member no cost transportation services during member outreach; gaps in care and case management calls; and member newsletters, member website, and member handbook. EPSDT mailers. Members received an annual mailer approximately 42 days prior to their birthday reminding them to schedule their well-child visit. Targeted outreach. Members enrolled in case management received calls from case management staff, who encouraged well-child visits and offered assistance in scheduling appointments. Member incentive. Members 12-18 years of age received a \$25



MHP State-Mandated PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
	adults 12-21 years of age.		gift card for completing an annual well-child visit. <ul style="list-style-type: none"> • Provider incentive. Providers were incentivized to complete well-child visits for members 12-17 years of age.

*Summarized list of MCO interventions.

Table 7: MHP MCO-Selected PIPs

MHP MCO-Selected PIPs			
PIP Topic	PIP Performance Measure (PM), Steward, and Population	PIP Aim	PIP Interventions*
<p>Reducing Out-of-State Placement for Children in Foster Care (MCO 1)</p>	<p>PM 1: Reducing out-of-state placement for children in foster care.</p> <p>Measure Steward: Homegrown measure</p> <p>Population: Child and adolescent members in foster care.</p>	<p>Will implementation of member, provider, and MCO interventions decrease the rate of out-of-state placement for MHP members by the end of the measurement year?</p>	<ul style="list-style-type: none"> ● Country Road initiative. Facilitated meetings and collaborated with providers to reduce length of stay in out-of-state placement and bring youth home. ● Increased provider capacity for children with severe emotional disorders. Worked to build provider community capacity to offer intensive behavioral health services in the member's home to optimize the transition from placement to home. Expanded virtual provider capacity to support members affected by SUDs. ● West Virginia System of Care clinical review. Coordinated efforts with the West Virginia System of Care to provide a comprehensive, objective, clinical review of designated youth. Out-of-state or at risk of going out-of-state youth are reviewed to determine and reduce gaps in services, barriers to in-state services, and system issues. ● Project Promise integrated case management. A youth priority list is created and triaged based on placement needs. The list is evaluated weekly to prioritize members in foster care with placement needs. ● Psychiatric residential treatment facility (PRTF) case management. Provided weekly contact with PRTFs to maintain contact and provide case management services to ensure there are no gaps in care upon discharge. Case managers review all members in this level of care and work with the PRTF, State, and guardians on transitions to reduce length of stay and minimize time spent in out-of-state facilities.

*Summarized list of MCO interventions.

The MCO will assess its performance on its selected PIP indicators by collecting and analyzing reliable data on an ongoing basis. The MCO must annually submit performance measurement data to the BMS using BMS-determined standard measures, including performance measures that may be developed by the CMS. The MCO must also demonstrate that its interventions result in meaningful improvement in its performance, as evidenced in repeat measurements of the quality indicators specified for each PIP undertaken by the MCO.

The PIPs are deemed successful and may terminate once sustained improvement is achieved. Sustained improvement is acknowledged through the documentation and maintenance of improved indicator performance. After improvement is achieved, it must be maintained for at least one year. The MCO must submit a CAP to the BMS that addresses deficiencies identified in any measurement data.

6.1.2 Quality of Care-Focused Provider Education

The BMS will engage in a collaborative process with participating MCOs to facilitate and oversee the development and implementation of quality of care-focused provider education initiatives. Throughout the process, the BMS and the MCOs will identify opportunities to improve the quality of care rendered by network providers, based on population health metrics, and leverage those opportunities through the development of educational intervention strategies, materials, and guidelines. These interventions will be designed to support providers in their efforts to render the highest quality of care possible and improve health outcomes for their patients. Quality of care-focused provider education strategies will identify a universe of network providers for whom the education developed could be beneficial and establish milestone goals, detailing the percentage of providers in the universe the plan will seek to educate through this initiative and the timeframe in which it plans to conduct education. The BMS will work with MCOs to ensure documentation of education reflects both the name(s) of the individual provider(s) educated and the particular topic being addressed to improve provider accountability.

6.2 Incentivizing Performance

6.2.1 Quality Withhold Program

In 2024, the BMS implemented a managed care quality withhold program based on HEDIS® measures of performance outcomes. The program is designed to drive quality improvement while being straightforward to administer. The 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. Improvement will be measured in three tiers, with a minimum level required to earn funds. Equal weight will be applied to each of the five selected measures (see *Table 8* below) for incumbent MCOs. Any withheld funds not earned back by the MCOs will go into an incentive pool. To be eligible for incentive pool payments, an MCO must meet or exceed the MHT average for the prior year. There will be an annual settlement process.

The BMS has aligned performance measures selected for the quality withhold program with those being addressed through the 2024-2027 Managed Care Quality Strategy. These measures reflect priority areas for the BMS, including SUD, chronic health conditions, and EPSDT services.

Table 8: Quality Withhold HEDIS® Measures

Quality Withhold Measures
Follow-Up After High-Intensity Care for SUD (7 Days Total) (FUI)
Oral Evaluation, Dental Services (OED) (Ages <1-20)
Controlling High Blood Pressure (CBP)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP – Total)
Well-Child Visits in the First 30 Months of Life (W30) (0-15 Months)

As a new MCO in the West Virginia market, HHOWV is not yet able to provide HEDIS® rates. The BMS has designated a set of operational performance metrics (*Appendix D*) that will be used in lieu of HEDIS® measures for HHOWV and any new MCO that may enter the West Virginia market.

6.2.2 Alternative Payment Models (APMs)

The BMS supports a value-based healthcare system with the goal to improve member experience and population health outcomes, contain healthcare costs through aligned incentives with the MCO and provider partners, and maintain a commitment to continuous quality improvement. To support this effort, the BMS requires the MCOs to adopt APMs that reward the delivery of high-quality and cost-efficient health care. The managed care contract requires the MCOs to implement the APMs, which aim to incentivize providers to focus on the quality of care provided rather than the volume of services rendered. For example, three MCOs have engaged provider groups in shared savings arrangements. The MCOs may also use the APMs to incentivize providers for tangible improvements to performance measures included in the Managed Care Quality Strategy. The MCOs report on their APMs annually and have demonstrated their commitment to APMs.

6.2.3 Directed Payment Program (DPP)

The DPP provides qualifying providers with additional dollars for Medicaid members utilizing their services and focuses more dollars to higher need settings. Created through the 2016 Medicaid Managed Care Final Rule, the DPPs allow the State to require the MCOs to pay providers according to certain rates or methods established or “directed” by the State. These payment arrangements can include setting a minimum and maximum payment rate for specific types of

health care providers as well as value-based payment arrangements that seek to advance the State's Managed Care Quality Strategy goals.

The BMS operates two DPPs as part of the MHT program: one aimed at hospitals and academic physicians, and another aimed at non-academic physicians employed by or subcontracted with hospitals. The DPPs provide qualifying hospitals with additional dollars for services, including inpatient admissions, outpatient services, and physician visits. Payments are based on Medicaid managed care utilization of services at each hospital.

The BMS continually revisits DPP quality measures to better ensure the payment arrangement will advance the goals and objectives of the Managed Care Quality Strategy, including goals around prevention, timely and effective care, care transitioning satisfaction, patient safety, and care coordination. Funds withheld and earned for distribution based on quality measure evaluations will be distributed as an additional payment with the quarter four distribution of funds. Funds not earned by a hospital will be forfeited.

6.3 Targeted Interventions/Strategies

The BMS is working collaboratively with other state agencies and stakeholders to implement a variety of targeted interventions and strategies to improve health outcomes for members. As part of implementation planning and ongoing operations, the BMS and these stakeholders are also working to determine how these interventions and strategies can be maximized to address goals outlined in this Managed Care Quality Strategy. Ongoing monitoring of these programs will provide the BMS with data for future monitoring and planning.

6.3.1 Mobile Crisis Intervention (MCI) Services

In September 2023, the BMS received State Plan approval from the CMS to implement MCI services for all Medicaid populations. The BMS is targeting implementation of these services for managed care populations beginning in July 2024. This benefit will provide members experiencing a suspected mental health and/or SUD-related crisis timely intensive supports, stabilization of the crisis event, and time-limited rehabilitation intervention services intended to achieve crisis symptom reduction. The 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.⁴⁷ The services are an important addition to the delivery system, meeting individuals in their communities in the time of crisis. Intervention services will link members to resources and engage them in treatment that will support long-term success.

Mobile crisis services are in alignment with Goals 3 and 4 of this Managed Care Quality Strategy, which are aimed at improving behavioral health outcomes and reducing the burden of SUDs, respectively.

6.3.2 Certified Community Behavioral Health Clinics (CCBHCs)

West Virginia is one of 15 states selected to receive a \$1 million CCBHC planning grant from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. CCBHCs are clinics with special designations designed to provide a comprehensive range of mental health and substance use services to anyone who requests care,

⁴⁷ West Virginia BMS. [State Plan Amendment 23-0003, Medicaid Community-Based Mobile Crisis Intervention Services Program](#). September 5, 2023. Accessed on February 15, 2024.

regardless of their ability to pay, benefiting all West Virginians. The CCBHCs ensure 24/7 access to crisis response and medication-assisted treatment, among other services. The BMS and BBH are working diligently to address the state's mental health crisis through implementation of CCBHCs in CY 2024.

CCBHC implementation is in alignment with Goals 3 and 4 of this Managed Care Quality Strategy, which are aimed at improving behavioral health outcomes and reducing the burden of SUDs, respectively. The demonstration is intended to increase access to services and make it easier for individuals to receive comprehensive, evidence-based behavioral health treatment in one place. The CCBHCs will be located in rural and underserved areas of the state and targeted to reach members who have historically been underserved in an effort to reduce health disparities. The State will partner with the CCBHCs to promote evidence-based practices, workforce development, and recovery-based and trauma-informed models of care.

6.3.3 Drug Free Moms and Babies (DFMB)

The West Virginia Perinatal Partnership developed the DFMB program with funding from the West Virginia DoHS and other organizations with the aim to develop an integrated approach to provide the best care for mothers and babies. Originally designed as a four-site pilot project, the program has grown to 20 clinical sites serving more than 4,000 women. Evaluation of the program has shown a significant reduction in illicit substance use by participants as well as improved birth outcomes for their children.⁴⁸

The program is aligned with Goals 3, 4, and 5 of this Managed Care Quality Strategy, which are aimed at improving behavioral health outcomes, reducing the burden of SUD, providing supports for whole-person wellness, and empowering individuals to self-manage their health.

6.3.4 Transforming Maternal Health Model (TMaH)

On January 6, 2025, the CMS announced that West Virginia was one of 15 states selected to participate in the TMaH. West Virginia was granted a federal award of \$1 million to be used over a performance period of 10 years.

The model will support the BMS 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. The BMS will partner with MCOs, maternal health providers, community-based organizations (CBOs), hospitals, health systems, and other agencies across the state or within designated implementation regions to carry out the core elements of the model. The model is designed to improve access to care, treatment, outcomes, and patient experience for mothers and their newborns while also reducing overall program expenditures.

The TMaH implementation aligns with the Managed Care Quality Strategy objective to increase usage of timely maternal and child health services. The model's required and optional components are organized around three key focus areas: access to care, infrastructure, and workforce; quality improvement and safety; and whole-person care delivery. The CMS will provide state-level supports to participating states, including infrastructure funding and resources, opportunities for statewide or sub-state implementation, health equity advancement, and collaboration and learning activities. Through the implementation of TMaH, West Virginia aims to address maternal health disparities and improve outcomes for birthing individuals and families across the state.

⁴⁸ ODCP. [Drug Free Mom and Babies \(DFMB\)](#) (n.d.). Page dated May 25, 2023. Accessed on February 15, 2024.



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6.3.5 SDoH

The 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 to improve long-term health outcomes and reduce disparities. The MCOs identify needs through an initial health risk assessment at enrollment and annual reassessments. The MCOs must collaborate and build partnerships with CBOs, public health departments, and/or social service providers to implement person-centered SDoH interventions. The MCOs are required to follow up on referrals to services to ensure the member has successfully accessed needed services.

The BMS has contractually required MCOs to adopt a more robust approach to collecting and analyzing SDoH data. The MCOs are required to perform data analytics to identify members' disparities and report on the effectiveness of evidence-based interventions. MCOs also encourage contracted providers to use International Classification of Diseases (ICD)-10 Z-codes on provider claims.

6.3.6 Value-Added Services (VAS)

Each MCO offers an array of VAS in addition to Medicaid-covered benefits and services. These “extra” services incentivize members to engage in their health care, including 24-hour help lines, support services for pregnant women, asthma education services, educational programs and equipment for members with diabetes, and incentives for wellness visits, dental care, smoking cessation, mammograms, and certain age-specific vaccines. The MCOs have targeted many of the VAS on the priority health conditions identified in the goals of the Managed Care Quality Strategy.

6.3.9 Disease Management Programs

All MCOs operate disease management programs to help members with diabetes, asthma, and other chronic conditions live healthier lives. The programs incorporate self-management education, member outreach, case management, and clinical support services. The programs engage patients in their care and promote effective care coordination. The programs align with Goal 2: reduce burden of chronic disease.

6.3.10 Senate Bill 820 SUD Initiatives

On March 8, 2024, the West Virginia (State) Legislature passed Senate Bill 820 (SB 820). SB 820 requires the BMS to develop and implement initiatives aimed at improving SUD services. The objective of SB 820 is to improve access to care and health outcomes for members with SUDs. There are three key components:

- Performance outcome measures to improve inpatient SUD care.
- A quality withhold program to incentivize MCO performance and enhance SUD outcomes (described in Section 6.2.1).
- Automatic member enrollment into the MHT program, expediting care coordination and treatment.

The BMS reviewed measures and received input from the SUD Measures Advisory Committee, comprised of representatives from the West Virginia Behavioral Healthcare Providers Association, the West Virginia Association of Addiction and Prevention Professionals, and state MCOs in July 2024. The advisory committee identified eight measures designed to help ensure the effectiveness and accountability of care, with the goal of improving treatment outcomes for individuals with SUD. The measures are being implemented on a phased schedule between January 1, 2025, and January 1, 2026.



Effective July 1, 2025, the BMS adopted automatic enrollment to an MCO for all Medicaid enrollees who are eligible for managed care. The purpose of this program is to promote better access to coordinated care and resources for members, especially those with SUDs. Previously, members who were eligible for MHT enrolled in FFS until they elected or were assigned to an MCO. Automatic member enrollment now occurs as soon as eligibility is determined, allowing the MCO to immediately coordinate care and treatment in the most appropriate setting.

These initiatives align with BMS' strategic plan for SUD services and access to care as well as Goal 4 of this Managed Care Quality Strategy.

Section 7: Conclusion

Access to high-quality health care is an essential element in fostering healthy and prosperous communities and families.⁴⁹ The 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. The quality measures selected for this strategy, paired with comprehensive managed care program reporting, monitoring, and evaluation, will support the BMS in achieving its goals. Delivering high-quality care is a continual and dynamic process. The BMS will work closely with the MCOs to continually monitor and assess performance in key priority areas outlined in [Section 3](#). This continuous evaluation will allow the BMS to identify areas for improvement and provide a roadmap for the development and implementation of future programs and interventions. The BMS will continually work to evolve its Managed Care Quality Strategy based on the results of its monitoring, assessment, and improvement activities to ensure it effectively drives improvement in the areas integral to the managed care programs.

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⁴⁹ West Virginia Executive. [Hurdles to Health. The State of Health Care in West Virginia](#). Miller, Olivia. February 22, 2023. Accessed on March 15, 2024.

Appendices

Appendix A: Quality Strategy Crosswalk

To ensure compliance with [42 CFR §438.340](#) and additional federal regulatory requirements in the 2021 CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit, *Table 9* provides a crosswalk of each required element to the corresponding sections in this Managed Care Quality Strategy where the element is located.

Table 9: Quality Strategy Crosswalk

42 CFR §438.340 - Managed Care State Quality Strategy Requirements			
Required State Elements	Criteria/Description	Regulatory References	Managed Care Quality Strategy Section No.
Section A: General Rule			
(a) General Rule	Each State contracting with an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) as defined in §438.2 or with a primary care case management (PCCM) entity as described in §438.310(c)(2) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP or PCCM entity.	§438.2 §438.310 §457.1240	N/A
Section B: Elements of the State Quality Strategy			
At a minimum, the State's quality strategy must include the following:			
(1) Network Adequacy and Provider Access Information	The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by §438.68 and §438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236 .	§438.68 §457.1218	5.1.2
(2) Continuous Quality Improvement	The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, PAHP, and PCCM entity described in §438.310(c)(2) .	§438.310(c)(2) §457.1240	Section 3
(3) Performance Improvement: Quality Metrics and Performance Targets	The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in §438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c) .	§438.330(c) §457.1240(b)	6.1.1 and Appendix B
(4) EQR	(4) The State's arrangements for annual EQR of the quality outcomes and timeliness of, and access to, the services covered under each managed care plan.	§438.350 §457.1250	4.3
(5) Transition of Care Policy	A description of the State's transition of care policy required under §438.62(b)(3) . Continued services to enrollees: The State must make its transition of care policy publicly available and provide instructions to	§438.62(b)(3) §457.1240(e)	5.1.5

42 CFR §438.340 - Managed Care State Quality Strategy Requirements			
Required State Elements	Criteria/Description	Regulatory References	Managed Care Quality Strategy Section No.
	enrollees and potential enrollees on how to access continued services upon transition.		
(6) Reduction of Health Disparities	The State’s plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.	§438.340(b)(6) §457.1240(e)	4.1.1, 4.1.3
(7) Intermediate Sanctions	For the MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	§438.700 - 730 §457.1270	5.4
(8) Identification of LTSS	The mechanisms implemented by the State to comply with §438.208(c)(1) (relating to the identification of persons who need LTSS or persons with special health care needs).	§438.208(c)(1) §457.1230(c)	N/A
(9) Non-duplication of EQR Activities	The information required under §438.360(c) (relating to non-duplication of EQR activities). The State must identify in its quality strategy under §438.340 the EQR activities for which it has exercised the option described in this section, and explain the rationale for the State’s determination that the Medicare review or private accreditation activity is comparable to such EQR activities.	§438.360(c) §457.1250(a)	4.3.1
(10) Definition of "Significant Change"	The State's definition of a “significant change” for the purposes of paragraph (c)(3)(ii) of this section. A copy of the revised strategy whenever significant changes, as defined in the State’s quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State’s Medicaid program.	§438.340(c)(3)(ii) §457.1240(e)	2.1
Section C: Development, Evaluation, and Revision			
In drafting and revising its quality strategy, the State must:			
(1) Public Comment	(1) Make the strategy available for public comment before submitting the strategy to CMS for review, including: (i) Obtaining input from the MSFAC (established by §431.12 of this chapter), beneficiaries, and other stakeholders. (ii) If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in §438.340(c)(2), consulting with Tribes in accordance with the State’s Tribal consultation policy.	§438.340(c)(1) §457.1240(e)	2.1.2
(2) Review and Update	(2) Review and update the quality strategy as needed, but no less than once every three years. (i) This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years.	§438.340(c)(2) §457.1240(e)	EQRO ATR

42 CFR §438.340 - Managed Care State Quality Strategy Requirements			
Required State Elements	Criteria/Description	Regulatory References	Managed Care Quality Strategy Section No.
(3) Submission to CMS	The State must submit to CMS the following: (i) A copy of the initial strategy for CMS comment and feedback prior to adopting it in final. (ii) A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	§438.10(c)(1) §438.340 (b)(11) §457.1207	Section 2
Section D: Availability			
(d) Availability	The State must make the final quality strategy available on the website required under §438.10(c)(3). The State must operate a website that provides the content, either directly or by linking to individual MCO, PIHP, PAHP, or PCCM entity websites specified in paragraphs (g), (h), and (i) of this section.	§438.10(c)(3) §457.1240(e)	Section 2

Appendix B: Quality Measures Tracking Tool

In collaboration with stakeholders, the OQM developed *Table 10* to track the progress of achieving the goals outlined in the Managed Care Quality Strategy. The table lists the goals, objectives, and associated quality measures that will be used to measure performance over the next three years. The BMS reviews the performance target data annually to determine what additional quality efforts should be implemented to meet the intended goals of the quality strategy. The BMS updates the tracking tool at least triennially to ensure incremental improvement is made and performance benchmarks align with the NCQA Quality Compass national benchmarks. BMS strives to meet the NCQA Quality Compass national average. Where the baseline exceeded the national average, the BMS selected a higher percentile (66th, 67th, 75th, 90th, or 95th percentile). The BMS recognizes that quality measures evolve over time to better align with health data standards and support new models of care delivery, and may, therefore, be updated to ensure the best quality measurement system is available.⁵⁰ In the event the performance measures selected for this quality strategy are updated, retired, or replaced, the BMS will make updates to the tracking tool accordingly. The BMS publishes a comprehensive list of quality metrics outlined in Appendix B below at least annually on its [website](#).

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Table 10: Quality Measures Tracking Tool

Objective	Quality Measures Name and Abbreviations*	Baseline**	Performance Target Year 3***
Goal 1: Improve the health and wellness of the state's Medicaid and CHIP populations through use of preventive services.			

⁵⁰ NCQA. [Retiring and Replacing HEDIS Measures, 2024-2026](#). July 17, 2023. Accessed on February 15, 2024.



Objective	Quality Measures Name and Abbreviations*	Baseline**	Performance Target Year 3***
Objective 1: Increase number of enrollees receiving preventive care to meet or exceed the NCQA Quality Compass National Average.			
1.1.1	(BCS-E) Breast Cancer Screening	NBM	52.43
1.1.2	(IMA) Immunizations for Adolescents – Combination 2	25.16	35.55
1.1.3	(LSC) Lead Screening in Children	53.80	59.36
1.1.4	(CCS) Cervical Cancer Screening	50.75	55.92
1.1.5	(COL) Colorectal Cancer Screening (Total)	27.15	TBD
Objective 2: Increase number of enrollees attending well and preventive visits to meet or exceed the NCQA Quality Compass National Average.			
1.2.1	(WCV) Child and Adolescent Well-Care Visits (3-11 Years)	59.57	67.94 (90 th percentile)
1.2.2	(WCV) Child and Adolescent Well-Care Visits (12-17 Years)	49.70	53.49 (66.67 th percentile)
1.2.3	(WCV) Child and Adolescent Well-Care Visits (18-21 Years)	23.58	25.99
1.2.4	(W30) Well-Child Visits in the First 30 Months of Life (0-15 Months)	51.86	56.76
1.2.5	(W30) Well-Child Visits in the First 30 Months of Life (15-30 Months)	72.14	77.78 (90 th percentile)
1.2.6	(OED) Oral Evaluation, Dental Services (Ages <1 through 20)	NBM	TBD
1.2.7	(TFC) Topical Fluoride for Children: (Ages 1 through 4)	NBM	TBD
Objective 3: Increase usage of timely maternal and child health services.			
1.3.1	(PRS-E) Prenatal Immunization Status – Combination	12.77	21.66
1.3.2	(PPC) Prenatal and Postpartum Care – Postpartum Care	78.84	84.59 (90 th percentile)
1.3.3	(PPC) Prenatal and Postpartum Care – Timeliness of Prenatal Care	87.16	91.07 (90 th percentile)
1.3.4	(LBW-CH) Live Births Weighing Less Than 2,500 Grams *Lower Rate is Better*	11.70 (MY 2021)	10.10
1.3.5	(LRCD-CH) Low-Risk Cesarean Delivery *Lower Rate is Better*	25.80 (MY 2021)	24.70
Goal 2: Reduce the burden of chronic disease.			
Objective 1: Increase the number of enrollees receiving treatment for respiratory conditions to meet or exceed the NCQA Quality Compass National Medicaid Average.			
2.1.1	(CWP) Appropriate Testing for Children with Pharyngitis (Total)	70.57	77.56 (66.67 th percentile)
2.1.2	(URI) Appropriate Treatment for Upper Respiratory Infection (3 months-17 years)	86.45	92.60
2.1.3	(URI) Appropriate Treatment for Upper Respiratory Infection (18-64 years)	70.68	81.09
2.1.4	(URI) Appropriate Treatment for Upper Respiratory Infection (Total)	82.02	89.85
Objective 2: Increase the number of enrollees receiving diabetes care to meet or exceed the NCQA Quality Compass National Medicaid Average.			
2.2.1	(EED) Eye Exam for Patients with Diabetes	38.15	51.47
2.2.2	(GSD) Glycemic Status Assessment for Patients with Diabetes	NBM	TBD

Objective	Quality Measures Name and Abbreviations*	Baseline**	Performance Target Year 3***
2.2.3	(KED) Kidney Health Evaluation for Patients with Diabetes (Total)	28.06	34.54
Objective 3: Increase the number of enrollees receiving treatment for hypertension to meet or exceed the NCQA Quality Compass National Medicaid Average.			
2.3.1	(CBP) Controlling High Blood Pressure	64.08	67.27 (75 th percentile)
Goal 3: Improve behavioral health outcomes.			
Objective 1: Increase the number of enrollees receiving follow-up care after behavioral health treatment to meet or exceed the NCQA Quality Compass National Medicaid Average.			
3.1.1	(ADD) Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	51.24	54.25 (90 th percentile)
3.1.2	(ADD) Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	55.93	59.75 (75 th percentile)
3.1.3	(AMM) Antidepressant Medication Management – Effective Acute Phase Treatment	71.63	74.16 (90 th percentile)
3.1.4	(AMM) Antidepressant Medication Management – Effective Continuation Phase Treatment	57.17	58.06 (90 th percentile)
3.1.5	(SAA) Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.22	66.94 (75 th percentile)
Objective 2: Increase the number of enrollees receiving behavioral health care and treatment.			
3.2.1	(CDF-AD) Screening for Depression and Follow-Up Plan: Age 18+	NBD	TBD
3.2.2	(CDF-CH) Screening for Depression and Follow-Up Plan: Ages 12-17	NBD	TBD
3.2.3	(APP) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	52.51	57.29
Goal 4: Reduce burden of SUD.			
Objective 1: Increase the number of enrollees receiving treatment for SUD to meet or exceed the NCQA Quality Compass National Medicaid Average.			
4.1.1	(POD) Pharmacotherapy for Opioid Use Disorder (Total)	37.39	40.34 (90 th percentile)
Objective 2: Improve coordination of care for enrollees receiving SUD treatment.			
4.2.1	(FUA) Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up (13-17)	44.00	53.19 (95 th percentile)
4.2.2	(FUA) Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up (18+)	59.50	Maintain
4.2.3	(COU) Risk of Continued Opioid Use ≥ 31 Days (Total) *Lower Rate is Better*	4.08	3.61
4.2.4	(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Day Follow-Up (Total)	39.65	49.55 (90 th percentile)
4.2.5	(FUI) Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Day Follow-Up (Total)	59.90	68.71 (90 th percentile)
Goal 5: Provide supports for whole-person wellness and empower individuals to self-manage their health.			
Objective 1: Increase the number of enrollees receiving smoking cessation services to meet or exceed the NCQA Quality Compass National Medicaid Average.			
5.1.1	(MSC) Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Strategies	42.78	45.43



Objective	Quality Measures Name and Abbreviations*	Baseline**	Performance Target Year 3***
5.1.2	(MSC) Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers and Tobacco Users to Quit	71.96	75.00 (66.67 th percentile)
5.1.3	(MSC) Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Medications	46.70	51.16
5.1.4	(Quality ID#226 NQF 0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention	NBM	TBD
Objective 2: Increase the number of enrollees receiving weight management counseling to meet or exceed the NCQA Quality Compass National Medicaid Average.			
5.2.1	(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition (Total)	73.75	76.04 (66.67 th percentile)
5.2.2	(WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity (Total)	71.08	72.51 (66.67 th percentile)

*Assume total measure population unless otherwise noted.

**Baseline MY 2022 unless otherwise noted.

***Year 3 performance target is NCQA average rate unless otherwise noted.

NBM indicates no benchmark available.

TBD indicates the performance target is to be determined.

Appendix C: Implementation and Maintenance Sample Plan

As the delivery system continues to evolve, the quality strategy provides a framework for the BMS to promote quality care for managed care members. The strategy’s goals and objectives reflect areas of greatest need so that the BMS and the MCOs can focus their efforts. Implementation and monitoring of the strategy build on use of existing infrastructure to the extent possible. The OQM will spearhead monitoring and review activities. The BMS will integrate the Managed Care Quality Strategy into existing activities, including MCO reporting, EQR activities, and contracting. *Table 11* outlines ongoing activities and dedicated reviews for monitoring the quality strategy.

Table 11: Annual Quality Strategy Related Activities

Activity	Timeline			
	Quarter 1 (Jan.-Mar.)	Quarter 2 (Apr.-Jun.)	Quarter 3 (Jul.-Sep.)	Quarter 4 (Oct.-Dec.)
MCO Reporting	<ul style="list-style-type: none"> Quarterly operating reports. PIP progress reports. DPP reporting. 	<ul style="list-style-type: none"> Quarterly operating reports. HEDIS® data.* QAPI annual evaluation. DPP reporting. 	<ul style="list-style-type: none"> Quarterly operating reports. Annual PIP reports. CAHPS® evaluation & action plan. Adult & Child Core Set Measures. APM report. DPP reporting. 	<ul style="list-style-type: none"> Quarterly operating reports. PIP progress reports. Network adequacy. DPP reporting.
Managed Care Activities	Draft the MCO contracts.			
EQR Activities	<ul style="list-style-type: none"> Systems Performance Site Reviews (SPR). Quarterly and annual 24/7 access to care report. Quarterly and annual grievance, appeal, denial (GAD) review. 	<ul style="list-style-type: none"> ATR. Quarterly 24/7 access to care review. Quarterly GAD review. Encounter data validation (EDV). NAV. Performance measure validation (PMV). 	<ul style="list-style-type: none"> Validate PIP reports. Annual SPR report. Quarterly 24/7 access to care report. EDV. Quarterly GAD review. NAV. PMV. 	<ul style="list-style-type: none"> Quarterly 24/7 access to care report. Quarterly GAD review. NAV. PMV.

Activity	Timeline			
	<i>Quarter 1 (Jan.-Mar.)</i>	<i>Quarter 2 (Apr.-Jun.)</i>	<i>Quarter 3 (Jul.-Sep.)</i>	<i>Quarter 4 (Oct.-Dec.)</i>
	<ul style="list-style-type: none"> Network adequacy validation (NAV). PMV. 			
Stakeholder Engagement	<ul style="list-style-type: none"> Monthly MCO meetings. 	<ul style="list-style-type: none"> Monthly MCO meetings. Review Managed Care Quality Strategy with additional stakeholder groups identified by the OQM (Year 1 – overview of updated strategy, review progress towards goals/objectives/ PMs in Years 2 and 3). 	<ul style="list-style-type: none"> Monthly MCO meetings. 	<ul style="list-style-type: none"> Monthly MCO meetings.

*HEDIS® MY includes data on encounters between January 1 and December 31 of the preceding year (e.g., HEDIS® MY 2023 represents data from December to January 2022).

Appendix D: New Market Entrant Withhold Performance Metrics

As a new MCO in the West Virginia market, HHOWV is not yet able to provide HEDIS® rates. The BMS has designated a set of operational performance metrics that will be used in lieu of HEDIS® measures for HHOWV and any new MCO that may enter the West Virginia market.

Table 12: New Market Entrant(s) Withhold Performance Metrics

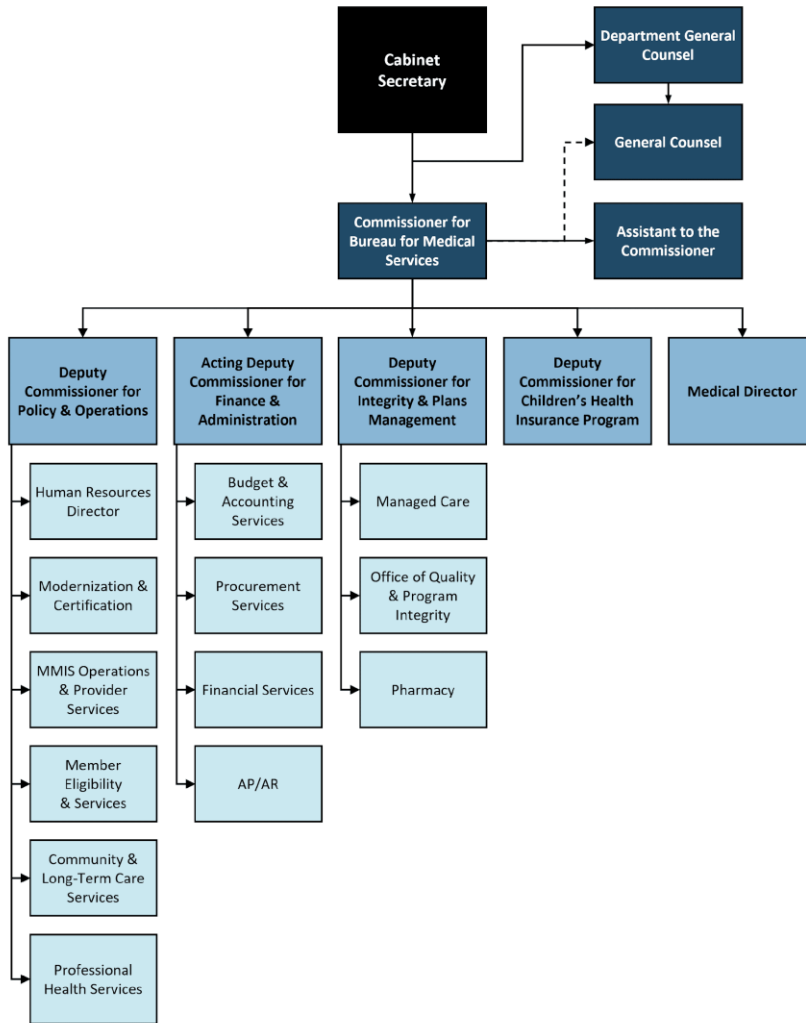
New Market Entrant(s) Performance Metrics for Evaluation
<p>Encounter Data Validation:</p> <ul style="list-style-type: none"> High Confidence – 98-100% (5%) Moderate Confidence – >96-97.99% (2%) Low Confidence – < 96% (0%)
<p>MCO Reporting:</p> <ul style="list-style-type: none"> Complete & Timely – >95-100% (5%) Complete & Timely – 90-95% (2%) Complete & Timely – Under 90% (0%)
<p>Member Call Center Performance:</p> <ul style="list-style-type: none"> Abandonment Call Rate – SLA* 0-2% (5%) Abandonment Call Rate – SLA >2-5% (2%) Abandonment Call Rate – SLA >5% (0%) Answer Time Benchmark – SLA <15 seconds (5%) Answer Time Benchmark – SLA 15-30 seconds (2%) Answer Time Benchmark – SLA >30 seconds (0%)
<p>Provider Call Center Performance:</p> <ul style="list-style-type: none"> Abandonment Call Rate – SLA 0-2% (5%) Abandonment Call Rate – SLA >2-5% (2%) Abandonment Call Rate – SLA >5% (0%) Answer Time Benchmark – SLA <15 seconds (5%) Answer Time Benchmark – SLA 15-30 seconds (2%) Answer Time Benchmark – SLA >30 seconds (0%)
<p>Clean Claims Processed with 30 days:</p> <ul style="list-style-type: none"> >95-100% of total clean claims paid within 30 calendar days (5%) >90-95% of total clean claims paid within 30 calendar days (2%) 0-90% of total clean claims paid within 30 calendar days (0%)

*SLA = Service-Level Agreement

Appendix E: BMS Organizational Charts

The BMS maintains an organizational structure committed to the implementation and oversight of the managed care programs that serve Medicaid and WVCHIP members. The BMS organizational chart is shown in *Figure 4*.

Figure 4: BMS Organizational Chart



Appendix F: Deemable Elements for Non-Duplication

Table 13: Deemable Elements for Non-Duplication

Deemable Elements for Non-Duplication - NCQA Accredited MCOs	
Information Requirements	
438.10 Information Requirements	(c)(1), (c)(6-7), (d)(1-6)*, (f)(1), f(3), (g)(1-4), (h)(1-4), (i)(1-3)
Access to Care	
438.114 Emergency and Post-Stabilization Services	(b), (c)(1)*, (d)
438.206 Availability of Services	(b)(1-5), (b)(7), (c)(1-3)
438.207 Assurances of Adequate Capacity and Services	(b)
438.208 Coordination and Continuity of Care	(b), (c)(2-4)
438.210 Coverage and Authorization of Services	(a)(3)(ii), (a)(4)(i), (a)(5)*, (b)(2-3), (c-d), (e)*
Structure and Operations	
438.214 Provider Selection	(b), (c)(1), (d)
438.224 Confidentiality	
438.230 Subcontractual Relationships and Delegation	(b), (c)(1), (c)(3)
Quality Measurement and Improvement	
438.236 Practice Guidelines	(b-d)
438.242 Health Information Systems	(a), (b)(2-4)*
438.330 QAPI Program	(a)(1), (b)(1-5)*, (c)(1-2)*, (e)(2)
Grievances	
438.402 General Requirements	(a-b), (c)(1)(i)(A), (c)(1)(ii), (c)(2-3)
438.404 Timely and Adequate Notice of Adverse Benefit Determination	(a-c)*
438.406 Handling of Grievances and Appeals	(a-b)
438.408 Resolution and Notification: Grievances and Appeals	(b-c), (d)(2), (e)
438.410 Expedited Resolution of Appeals	(a-c)
438.414 Information about the Grievance System to Providers and Subcontractors	
438.416 Record Keeping Requirements	(a-b)
438.420 Continuation of Benefits While the MCO or PIHP Appeal and the State Fair Hearing are Pending	(a-d)
438.424 Effectuation of Reversed Appeal Resolutions	(a-b)



West Virginia 2024-2027 Quality Strategy

* NCQA has a requirement but some of the federal requirements are not included in NCQA's accreditation survey and the state or EQRO must conduct review for such elements.

Appendix G: Acronyms

Acronym	Term
ATR	Annual Technical Report
BBH	Bureau for Behavioral Health
BCF	Bureau for Children and Families
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BSS	Bureau for Social Services
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCBHC	Certified Community Behavioral Health Center
CDC	Center for Disease Control and Prevention
CHIP	Children's Health Insurance Program
COPD	Chronic Obstructive Pulmonary Disease
CMS	Center for Medicare & Medicaid Services
CSED	Children with Serious Emotional Disorders
CSEDW	Children with Serious Emotional Disorders Waiver
CY	Calendar Year
DFMB	Drug Free Moms and Babies
DEA	Drug Enforcement Administration
DoHS	Department of Human Services
DOJ	Department of Justice
DPP	Directed Payment Program
DSS	Decision Support System
DW	Data Warehouse
ECP	Essential Community Provider
EDS	Enterprise Data Solutions
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
HCBS	Home and Community-Based Services
HEDIS®	Healthcare Effectiveness Data and Information Set
HHOVV	Highmark Health Options of West Virginia
MCI	Mobile Crisis Intervention
MCO	Managed Care Organization
MHP	Mountain Health Promise
MHT	Mountain Health Trust
MIS	Office of Management Information Services
MMIS	Medicaid Management Information Services
MSFAC	Medical Services Fund Advisory Council
MY	Measurement Year
NCQA	National Committee for Quality Assurance
OB-GYN	Obstetrics and Gynecology
OSA	Office of Shared Administration, West Virginia Departments of Health, Health Facilities, and Human Services



Acronym	Term
OQM	Office of Quality Management
PA	Physician Assistant
PAHP	Prepaid inpatient health plan
PCP	Primary Care Provider
PIHP	Prepaid inpatient health plan
PIP	Performance Improvement Project
PM	Performance Measure
QAPI	Quality Assurance and Performance Improvement
QIA	Quality Improvement Advisory (Council)
RAPIDS	Recipient Automated Payment and Information Data System
RHC	Rural Health Clinic
SAMSHA	Substance Abuse and Mental Health Services Administration
SDoH	Social Determinants of Health
SFY	State Fiscal Year
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
QAPI	Quality Assessment and Performance Improvement
QS	Quality Strategy
WVCHIP	West Virginia Children’s Health Insurance Program