

**State of West Virginia**  
**Department of Health and Human Resources**  
**Bureau for Medical Services**



**Draft Access Monitoring Review Plan**

**Prepared for Public Comment**

**July 13, 2016**

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## Notice Regarding the Public Comment Period for the West Virginia Access Monitoring Review Plan

In accordance with 42 Code of Federal Regulations (CFR) Part 477, the Department of Health and Human Resources, Bureau for Medical Services provides notice of the Draft Access Monitoring Review Plan (Plan) being made available for public comment effective July 13, 2016, for a period no less than 30 days. After the public comment period has closed and comments are reviewed, the Plan will be updated and associated comments incorporated into the final version for submission to the Centers for Medicare and Medicaid Services (CMS).

The Draft Plan is available for public viewing and comment at the below location:  
<http://www.dhhr.wv.gov/bms/Public%20Notices/Pages/default.aspx>.

Comments regarding the Plan can be submitted in one of the ways listed below:

Feedback Method	Contact Information
<b>Mail:</b>	West Virginia Department of Health and Human Resources, Bureau for Medical Services ATTN: Access to Care 350 Capitol Street, Room 251 Charleston, WV 25301 <b>Note:</b> Mailings must be postmarked no later than August 16, 2016.
<b>Email:</b>	<a href="mailto:MedicaidATC@wv.gov">MedicaidATC@wv.gov</a> <b>Note:</b> Comments delivered via email must be received no later than 5:00pm August 17, 2016.
<b>Provider and Member Access Monitoring Plan Survey:</b>	Reviewers are encouraged to participate in a Provider and Member Access Monitoring Plan feedback survey located at the following location: <a href="http://www.dhhr.wv.gov/bms">http://www.dhhr.wv.gov/bms</a> <b>Note:</b> Comments must be received by August 17, 2016.
<b>Phone:</b>	(304) 558-1700

## 1. Overview

The purpose of this section is to provide a brief overview of West Virginia's Medicaid program, as well as enrollment statistics specific to providers and beneficiaries. This section will also include information specific to the State's Medicaid service delivery model.

To highlight the inception of the Access Monitoring Review Plan, this section will include a brief summary of 42 Code of Federal Regulations (CFR) 447.203 as well as the State's commitment to fulfill the regulation.

On November 2, 2015, CMS issued *42 CFR Part 447.203 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services (Final Rule)*. This final rule requires states to develop an Access Monitoring Review Plan (Plan) that includes an analysis of access to covered services under the Medicaid Fee-for-Service (FFS) program. As required by CMS within the Final Rule, certain Medicaid categories of services covered under the FFS programs would be continuously monitored in support of assuring beneficiary access to covered care and services.

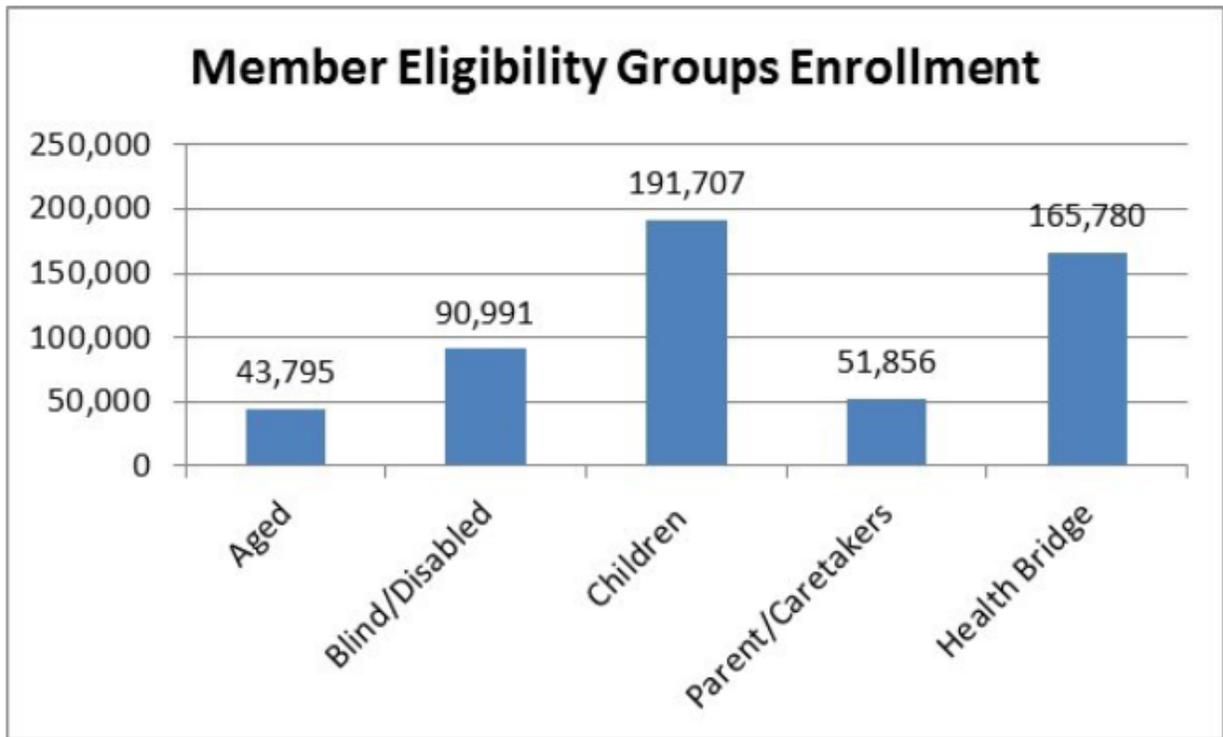
The West Virginia Department of Health and Human Resources (DHHR) Bureau for Medical Services (BMS) is the designated agency responsible for the administration of the State's Medicaid program. BMS provides access to healthcare for Medicaid-eligible individuals in accordance with Section 1902(a)(30)(A) of the Social Security Act.

Part of the mission of the West Virginia Medicaid program is to provide access to appropriate healthcare for Medicaid-eligible individuals. In its administration of the program, BMS strives to assure access to appropriate, medically necessary, and quality healthcare services for all members while maintaining accountability for the use of resources.

As of 2015, according to the Census Bureau, West Virginia has a population of approximately 1.84 million citizens. According to the BMS State Fiscal Year (SFY) Annual 2015 Report, the average number of West Virginians who received Medicaid services in SFY 2015 was 546,000, or approximately 30% of the State's citizens. This number does not include member participation in the West Virginia Children's Health Insurance Program (WVCHIP).

West Virginia Medicaid provides coverage to pregnant women; children; very low-income families; individuals who are aged, blind, and/or disabled; medically needy populations; and the Health Bridge (expansion) population, inclusive of individuals between the ages of 19 and 64 who have incomes at or below 138% of the Federal Poverty Level (FPL). **Figure 1.1 Medicaid Enrollment by Eligibility Group**, obtained from the SFY Annual 2015 Report, highlights the number of people enrolled in Medicaid by category in FY 2015.

Figure 1.1 Medicaid Enrollment by Eligibility Group



In addition to a FFS healthcare delivery system, West Virginia Medicaid maintains a managed care healthcare delivery system known as West Virginia Mountain Health Trust (WVMHT). As seen in the table below, over the course of the 2013-2015 calendar year enrollment in WVMHT experienced an increase of much greater magnitude than the traditional FFS Medicaid program from 2014 to 2015. This increase was in large part due to the State's efforts to transition the Medicaid expansion population, also known as the HealthBridge population, from the FFS healthcare delivery model to WVMHT (Managed Care).

Table 1.1 Member Enrollment by Healthcare Delivery Model

Member Enrollment by Program, 2013-2015			
Healthcare Delivery Model	2013	2014	2015
Medicaid FFS	278,615	458,956	489,484
WV Mountain Health Trust	235,619	264,550	437,006

As a participant in the Affordable Care Act's (ACA) Medicaid Expansion, the number of West Virginians receiving health insurance through Medicaid has increased more in West Virginia than in any other state. As of April 6, 2015, the State's Medicaid Management Information System (MMIS) fiscal agent, Molina Medicaid Solutions reported approximately 155,570 West Virginians were now covered by the ACA Medicaid expansion, with an estimated 166,000 newly eligible for coverage. Although there has been an increase in Medicaid enrollment, West Virginia has seen the per-person costs decrease, in part due to implementation of managed care programs and other reforms that the State has put into place.

Given the importance of ensuring that members have adequate access to services, BMS, in compliance with the Final Rule, will utilize the processes outlined within this Access Review Plan to monitor Access to Care (ATC) across the ATC service categories on a regular basis as defined in **Approach to Monitoring ATC**.

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## 2. Purpose of Access Monitoring Plan

This section highlights the purpose of the State of West Virginia's Access Monitoring Plan. It will also provide an overview of the Plan, its intended audience, and details specific to how the plan will be maintained and updated.

The purpose of the West Virginia Access Monitoring Plan (Plan) is to identify a data-driven approach to monitoring ATC across a subset of Medicaid FFS service categories to assist in determining access sufficiency and remediating any identified deficiencies.

The following subset of Medicaid service categories provided under a FFS arrangement are analyzed for the purposes of this Plan:

- Primary Care Services
- Physician Specialist Services
- Behavioral Health Services
- Home Health Services

Although the Final Rule identifies prenatal and postnatal obstetric services as an ATC service category, West Virginia did not include this service category in their analysis as it is supported by the State's managed care healthcare delivery system, WVMHT.

Additionally, while the option to select additional service categories was provided by the Final Rule, the State elected to not include any additional service categories.

The Access Monitoring Plan defines an ongoing access monitoring analysis that describes data sources, methodologies, baselines, assumptions, trends, and factors specific to reviewing West Virginia Medicaid ATC. This information will be used to assist in monitoring the sufficiency of ATC. For more information on the State's overall access monitoring analysis, please refer to **Section 4.0 Data Findings and Analysis**.

Across the above service categories, the Plan identifies data elements specific to:

1. The extent to which beneficiary needs are fully met
2. The availability of care through enrolled providers
3. Changes in beneficiary service utilization
4. Aggregate comparisons between Medicaid rates and rates paid by other public and private payers

West Virginia will update this Plan every three years based on feedback from members and providers, as well as current and future changes to the State's Medicaid Environment. This Plan may also be included in the submission of any applicable State Plan Amendment to CMS.

### 3. Executive Summary

The purpose of this section is to provide a brief summary of the State of West Virginia's Access Monitoring Plan, methodology, analysis, and findings.

In support of the CMS issued 42 CFR Part 447.203 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services (Final Rule), the State of West Virginia developed an Access Monitoring Plan that includes a data-driven approach to monitoring and reviewing ATC across the following Medicaid FFS service categories:

- Primary Care Services
- Physician Specialist Services
- Behavioral Health Services
- Home Health Services

The data-driven approach and findings contained herein will be updated triennially; however, the approach to monitoring ATC, will be implemented during the interim in accordance with the approach defined within **Approach to Monitoring ATC**.

Analysis of ATC across the aforementioned service categories within the 2013 – 2015 calendar years has identified the following:

- The number of members enrolled in West Virginia Medicaid increased by approximately 233,424 members, or 82%.
- The number of providers enrolled in West Virginia Medicaid increased by approximately 500 providers, or 3.75%.
- The number of members enrolled per provider enrolled increased from 80 members per provider in 2013 to 140 members per provider in 2015, an approximately 68% change.
- Member utilization rates across all age categories declined during the 2013 – 2015 calendar years, most notably across the ACA expansion population ages 18–64.
- In 2013, approximately 15.6 million claims were submitted by ATC specific service category providers, while in 2015, 19.2 million claims were submitted, an approximate 23% increase. Although this is an approximate 23% increase, it is nearly two million less than what was submitted in 2014 for services analyzed in support of the Final Rule.
- Although 13% higher than the National average of 66%, West Virginia Medicaid rates are 21% lower than those offered for Medicare patients.

Analysis of members' ATC within each of the individual aforementioned service categories has identified the following:

- Enrollment across the primary care services categories expanded by approximately 12% during the 2013 – 2015 timeframe, in large part due to the rate increase supplied to primary care service providers in accordance with the ACA.
- Physician specialist services experienced the largest decline in enrollment over the 2013 – 2015 calendar years (approximately 180 providers), in large part due to the

State's transition of members from FFS to WVMHT, the States managed care efforts; however, this may also be attributed to the State's provider revalidation effort.

- There were approximately 575 members per provider within the State's behavioral health services category during the 2013 calendar year, whereas, at the close of the 2015, this number was up approximately 82% to 1000 members per behavioral health services provider.
- Although access to behavioral health services and home health services may be available in other areas of the State, there are approximately nine counties in West Virginia without enrolled behavioral health services providers and 20 counties in the State without enrolled home health providers.

Findings indicate that, although no immediate access deficiency has been determined, the State will continue monitoring services identified herein, consider these findings, and expand upon the State's approach to monitoring ATC in areas defined throughout the Plan.

For more information on the State's data analysis and findings, please refer to **Data Findings and Analysis**, and, for more information on the State's approach to monitoring ATC, please refer to **Approach to Monitoring ATC**.

## 4. Data Findings and Analysis

The purpose of this section is to describe West Virginia Medicaid Provider and Beneficiary data as well as the associated analysis of the data specific to West Virginia ATC. The data will focus on the following services (“ATC Service Categories”):

- Primary Care Services
- Physician Specialists
- Behavioral Health Services
- Home Health Services

This section will also provide an analysis of the above services as they relate to the following data elements to inform the overall approach to monitoring ATC:

- Provider Enrollment
- Provider Types and Specialties
- Beneficiary Eligibility, Gender, and Age Characteristics
- Beneficiary Requests for Assistance
- Beneficiary Perceptions of ATC
- Beneficiary Utilization of Services
- Medicaid, Medicare, and Other Payer Rates

As a part of the Final Rule, states are required to document ATC measures by which Medicaid FFS service categories can be continuously monitored. The Final Rule also requires states to review data and trends to evaluate ATC for covered services, and to supply processes to obtain public input on the adequacy of access to covered services in the Medicaid FFS program.

The Final Rule also requires that the Access Monitoring Plan (Plan) detail an access monitoring analysis that includes:

*“...data sources, methodologies, baselines, assumptions, trends and factors, and thresholds that analyze and inform determinations of the sufficiency of access to care which may vary by geographic location within the state and will be used to inform state policies affecting access to Medicaid services such as provider payment rates, as well as the items specific in this section. The Access Monitoring Plan must specify data elements that will support the state’s analysis of whether beneficiaries have sufficient access to care. The plan and monitoring analysis will consider:*

- *The extent to which beneficiary needs are fully met;*
- *The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;*
- *Changes in beneficiary utilization of covered services in each geographic area*

- *The characteristics of the beneficiary population (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities); and*
- *Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service”*

The following subsections detail the State of West Virginia’s data collection methodology, analysis, and findings across each of the respective FFS Medicaid ATC service categories. As the State continues monitoring access to covered FFS Medicaid services, the following methodology, analysis, and findings are subject to change.

#### **4.1 Methodology**

To support the State of West Virginia’s Medicaid FFS ATC measures, baselines, and trends, the State requested three years of Medicaid FFS data across the aforementioned ATC specific service categories from their MMIS fiscal agent. The request included, but was not limited to:

- Characteristics of the Medicaid Member Population (age, sex, geographical location, enrolled service category, etc.)
- Member Utilization of Services by Service Category
- Requests for Assistance in Locating Services
- Available Services by Geographic Location
- FFS and Capitation Expenditures
- Fee Schedules

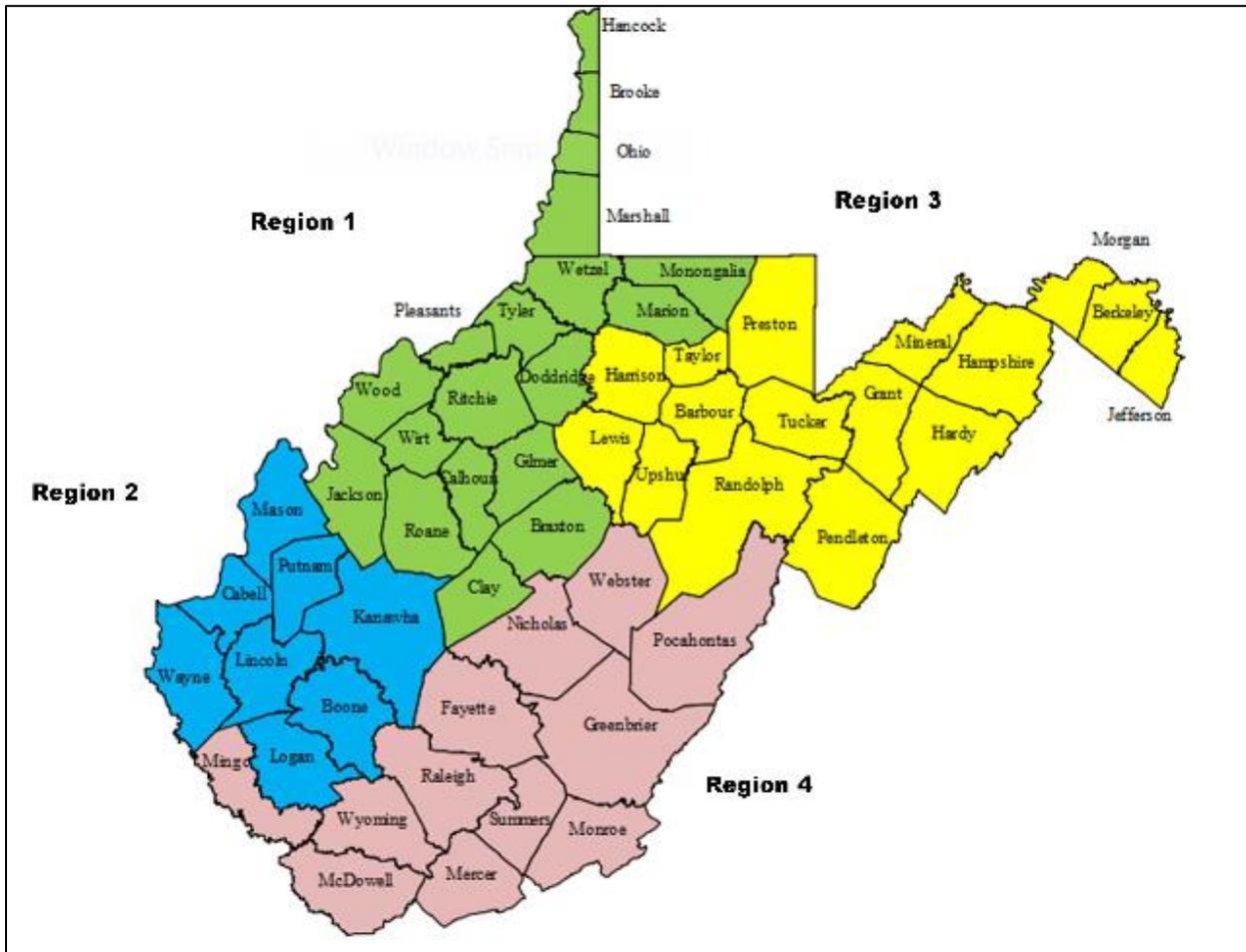
Additionally, the State requested assistance from their data warehouse vendor in developing a geographical representation of member and provider locations for the ATC-specific service categories. This analysis is still under development and was not included in this version of the Access Monitoring Plan.

The county-level analysis herein shows that, in many cases, a county is completely devoid of providers that fall into a given ATC Service Category (notably Behavioral Health and Social Services and Home Health Services). While it is indicative of the density of providers in a given area, that a county does not have a given type of provider does not automatically mean that that county’s residents do not have access to needed care. As noted above, further exploration of the impact of the geographical distribution of members and providers is being conducted by the State and will be included in a future version of the Plan.

Additionally, although the State planned to conduct a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey independently of the effort to develop this Plan, the approval to release a request for quotations (RFQ) to candidate vendors to procure assistance in the development and delivery of the survey has not been finalized. As such, the State has developed surveys (Appendices C and D) to be regularly available to the provider and member communities to assist in the qualification and quantification of perceptions of ATC. These surveys will be new to the provider and member community, and will be enacted upon CMS approval of the Access Monitoring Plan.

In addition to the surveys within Appendices C and D, the State is also engaged in monitoring factors that may affect perceptions of ATC, such as the relative presence of enrolled providers to eligible members in a given geographical area (i.e., a county). For the purposes of summarizing our findings as they relate to perceptions of ATC, West Virginia counties were divided into four regions, as reflected in **Figure 4.1 Geographic Representation of Counties in West Virginia by Region** below.

**Figure 4.1 Geographic Representation of Counties in West Virginia by Region**



The above regional divisions will be referenced throughout the following sections.

Lastly, in an effort to compare the Medicaid rates of West Virginia against those of Medicare and other private payers, the State gathered Medicare rates from [www.cms.gov](http://www.cms.gov) and compared those rates to fee schedules provided as a part of the request from the State MMIS fiscal agent.

The following subsections highlight the State of West Virginia's ATC analysis initially representative of all service categories, and then broken down individually by each of the following service categories:

- Primary Care Services
- Physician Specialists

- Behavioral Health Services
- Home Health Services

Across each of the above services, visual aids and/or narrative descriptions have been added within each of the following sections to supplement the following data measures:

- Provider Enrollment
- Provider Types and Specialties
- Beneficiary Eligibility, Gender, and Age Characteristics
- Beneficiary Requests for Assistance
- Beneficiary Perceptions of ATC
- Beneficiary Utilization of Services
- Medicaid, Medicare, and Other Payer Rates

#### **4.1.1 Data Parameters and Related Assumptions**

The following data parameters were used in accordance with the State's request for data identified and were analyzed in the Access Monitoring Plan:

- Data contained within the Access Monitoring Plan is representative of the following service categories, all of which are further defined by their related provider types and specialties, as identified in Appendix A:
  - Primary Care Services
  - Physician Specialists
  - Behavioral Health Services
  - Home Health Services
- The data within the Access Monitoring Plan is specific to the West Virginia Medicaid FFS healthcare delivery system, and contains limited Managed Care findings outside of those represented in **Section 1.0 Overview** and **Section 4.2.6 Medicaid, Medicare, and Other Payer Rates**.
- Unless otherwise specified, findings and analysis within the Access Monitoring Plan are representative of calendar years 2013, 2014, and 2015.
- WVCHIP data was not included as a part of the Access Monitoring Plan.
- The provider enrollment data within the Access Monitoring Plan is representative of both rendering and group providers.

Consideration for margin of error should be provided by readers to the State, fiscal agent, and data warehouse vendor in response to the Access Monitoring Plan's related data, findings, and analyses.

#### **4.2 Findings Across All Service Categories**

The following represents the State of West Virginia's ATC findings inclusive of the aforementioned service categories (primary care services, physician services, behavioral health services, and home health services).

Although the Final Rule identifies prenatal and postnatal obstetric services (inclusive of labor and delivery) as an ATC-specific service category, West Virginia did not include this service

category in their analysis as it is supported by the State's managed care healthcare delivery system, WVMHT.

#### 4.2.1 Provider Enrollment

From calendar years 2013 through 2015, the State of West Virginia experienced a 3.75% increase in provider enrollment across the ATC categories of services. Of the category of services that experienced an increase, primary care services experienced the largest increase at approximately 12%, with an addition of approximately 690 providers from 2013.

The increase in provider enrollment across ATC-specific services may be attributed to the following reasons:

- Beginning in 2013, the State of West Virginia kicked off their Provider Revalidation effort
- Increased support for the ACA Medicaid Expansion beneficiary population
- Increased support for physicians providing primary care services to Medicaid beneficiaries under the ACA

Over the same three years, the State experienced a decrease in provider enrollment across physician specialist services and behavioral health and social services. The largest of these decreases was within the physician specialist services service category, which experienced a loss in enrollment of approximately 182 providers, or nearly 2.6% of the physician specialist service–related providers.

For a more detailed analysis of provider enrollment findings specific to ATC service categories, please refer to **Table 4.1 Number of Enrolled Providers by Service Area, 2013 – 2015**

**Table 4.1 Number of Enrolled Providers by Service Area, 2013 – 2015**

Number of Enrolled Providers by Services				
Services	2013	2014	2015	% Change
Physician Specialist Services	7,093	7,182	6,911	-2.57%
Behavior Health and Social Services	538	542	532	-1.12%
Home Health Services	64	64	65	1.56%
Primary Care Services	5,712	6,174	6,402	12.08%
<b>Total</b>	<b>13,407.00</b>	<b>13,962.00</b>	<b>13,910.00</b>	<b>3.75%</b>

Geographically, of the 55 counties in West Virginia, 36 counties experienced an increase in the number of enrolled providers across the ATC service categories, and 15 of the remaining 55 counties experienced a decrease in provider enrollment. Of the five neighboring states (Kentucky, Maryland, Ohio, Pennsylvania, and Virginia), four experienced an increase in West Virginia Medicaid provider enrollment. The one remaining state saw provider enrollment numbers decrease from 2013 – 2015 across the five ATC services.

**Table 4.2 Percentage of Increased/Decreased Provider Enrollment by County, 2013 – 2015**

illustrates a percentage of increased and decreased provider enrollment by county and/or state, as well as highlights the total number of providers enrolled across ATC service categories by county and/or state. This table also takes into account the percentage of increase or decrease in provider enrollment between the 2013 and 2015 calendar years.

**Table 4.2 Percentage of Increased/Decreased Provider Enrollment by County, 2013 – 2015**

Number of Enrolled Providers by County/Commonwealth				
County/Commonwealth	2013	2014	2015	% Change
RITCHIE	18.00	17.00	13.00	-27.78%
PENNSYLVANIA (COMMONWEALTH)	2,001.00	1,964.00	1,578.00	-21.14%
BROOKE	64.00	61.00	54.00	-15.63%
WAYNE	44.00	43.00	38.00	-13.64%
WETZEL	53.00	50.00	46.00	-13.21%
DODDRIDGE	8.00	8.00	7.00	-12.50%
PLEASANTS	8.00	9.00	7.00	-12.50%
MINGO	49.00	47.00	44.00	-10.20%
NICHOLAS	79.00	73.00	71.00	-10.13%
MARSHALL	66.00	61.00	61.00	-7.58%
LOGAN	129.00	128.00	121.00	-6.20%
LINCOLN	30.00	30.00	29.00	-3.33%
BARBOUR	32.00	31.00	31.00	-3.13%
HAMPSHIRE	32.00	31.00	31.00	-3.13%
UPSHUR	73.00	73.00	71.00	-2.74%
GREENBRIER	170.00	176.00	169.00	-0.59%
CLAY	23.00	23.00	23.00	0.00%
PENDLETON	15.00	14.00	15.00	0.00%
TUCKER	12.00	13.00	12.00	0.00%
TYLER	20.00	20.00	20.00	0.00%
KENTUCKY (COMMONWEALTH)	678.00	706.00	680.00	0.29%
MARION	172.00	173.00	173.00	0.58%
MERCER	291.00	321.00	295.00	1.37%
FAYETTE	121.00	123.00	124.00	2.48%
RANDOLPH	123.00	121.00	127.00	3.25%

<b>Number of Enrolled Providers by County/Commonwealth</b>				
<b>County/Commonwealth</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
HARDY	26.00	28.00	27.00	3.85%
WOOD	389.00	407.00	407.00	4.63%
OHIO (COMMONWEALTH)	1,875.00	1,942.00	1,962.00	4.64%
JACKSON	59.00	62.00	62.00	5.08%
HARRISON	321.00	339.00	339.00	5.61%
OHIO	367.00	385.00	389.00	5.99%
WYOMING	28.00	32.00	30.00	7.14%
KANAWHA	1,244.00	1,308.00	1,343.00	7.96%
POCAHONTAS	25.00	23.00	27.00	8.00%
MINERAL	49.00	55.00	53.00	8.16%
VIRGINIA (COMMONWEALTH)	1,428.00	1,480.00	1,550.00	8.54%
CABELL	749.00	806.00	829.00	10.68%
ROANE	32.00	34.00	36.00	12.50%
BRAXTON	28.00	33.00	32.00	14.29%
GILMER	7.00	5.00	8.00	14.29%
MASON	55.00	60.00	63.00	14.55%
TAYLOR	30.00	32.00	35.00	16.67%
PUTNAM	101.00	106.00	119.00	17.82%
MONONGALIA	816.00	885.00	966.00	18.38%
LEWIS	53.00	60.00	63.00	18.87%
MARYLAND (COMMONWEALTH)	414.00	451.00	493.00	19.08%
PRESTON	52.00	53.00	62.00	19.23%
MCDOWELL	31.00	34.00	37.00	19.35%
RALEIGH	352.00	406.00	422.00	19.89%
BERKELEY	229.00	246.00	276.00	20.52%
MORGAN	23.00	21.00	28.00	21.74%
MONROE	18.00	18.00	22.00	22.22%
JEFFERSON	95.00	112.00	117.00	23.16%
HANCOCK	92.00	103.00	116.00	26.09%
SUMMERS	14.00	16.00	18.00	28.57%

Number of Enrolled Providers by County/Commonwealth				
County/Commonwealth	2013	2014	2015	% Change
CALHOUN	9.00	10.00	12.00	33.33%
WIRT	6.00	8.00	8.00	33.33%
BOONE	32.00	36.00	43.00	34.38%
GRANT	33.00	35.00	49.00	48.48%
WEBSTER	14.00	15.00	27.00	92.86%
<b>Grand Total</b>	<b>13,407.00</b>	<b>13,962.00</b>	<b>13,910.00</b>	<b>3.75%</b>
<b>Total Averages</b>	<b>223.45</b>	<b>232.70</b>	<b>231.83</b>	<b>3.75%</b>

During the 2013 – 2015 calendar years, West Virginia experienced an increase of 3.39% in the enrollment of providers with provider types and specialties specific to applicable ATC service categories. Although the State experienced an overall increase in the number of enrolled providers with specific provider types and specialties, the State also experienced a decrease in enrollment greater than 20% for providers enrolled in the optician, traumatic brain injury (TBI) therapist, and mental hospital less than 21 provider types.

Refer to **Table 4.3** for the number of enrolled providers across ATC-specific provider types.

**Table 4.3 Number of Enrollment Providers by ATC-Specific Provider Type**

Number of Enrolled Providers by ATC Specific Provider Type				
Provider Type	2013	2014	2015	% Change
HABILITATION	No Providers	1	2	N/A*
HEALTH DEPARTMENTS	No Providers	No Providers	1	N/A*
INDEPENDENT RADIOLOGY	No Providers	No Providers	2	N/A*
OPTICIAN	45	46	32	-28.89%
THERAPIST	19	16	14	-26.32%
MENTAL HOSPITAL <21	36	36	29	-19.44%
PSYCHOLOGIST	334	325	307	-8.08%
CRNA	949	977	903	-4.85%
PHYSICIAN	10,180	10,322	9,889	-2.86%
RURAL HEALTH CLINIC	56	55	55	-1.79%
DENTAL	616	610	608	-1.30%
OPTOMETRIST	217	213	218	0.46%
PODIATRIST	100	99	101	1.00%
MENTAL HEALTH REHABILITATION	76	78	77	1.32%

<b>Number of Enrolled Providers by ATC Specific Provider Type</b>				
<b>Provider Type</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
HOME HEALTH AGENCY	65	65	66	1.54%
INDEPENDENT LAB	203	212	207	1.97%
CHIROPRACTOR	150	147	157	4.67%
RESPITE AND HABILITATION	55	57	58	5.45%
MENTAL HEALTH CLINIC	29	31	31	6.90%
AUDIOLOGIST	62	68	67	8.06%
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	176	185	206	17.05%
NURSE PRACTITIONER	746	947	1176	57.64%
SOCIAL WORKER	8	16	19	137.50%
PHYSICIAN ASSISTANT	49	95	117	138.78%
GROUP PROVIDER	116	277	349	200.86%
NON-PHYSICIAN PRACTITIONER	1	18	82	8100.00%
<b>Grand Total</b>	<b>14,288</b>	<b>14,896</b>	<b>14,773</b>	<b>3.39%</b>
<b>Total Average</b>	<b>549.54</b>	<b>572.92</b>	<b>568.19</b>	<b>3.39%</b>
<i>*The percent in change from the years 2013 – 2015 could not be calculated due to the absence of providers in 2013.</i>				

Overall findings indicate that provider enrollment increased during the 2013 – 2015 calendar years across nearly 75% of West Virginia counties. A county-level analysis, in conjunction with a detailed analysis of provider enrollment by specialty and provider type, also indicates an upward trend in provider enrollment. However, the State will study the decrease in enrollment experienced by approximate 25% of counties/states as part of their ongoing access monitoring effort.

#### **4.2.2 Beneficiary Eligibility, Gender, and Age Characteristics**

West Virginia experienced approximately an 82% increase in Medicaid members eligible for services within the ATC-specific service categories. Although enrollment across all age categories rose between the periods from 2013 – 2015, the largest increase in enrollment was specific to enrollees ages 18–44.

The following table highlights total Medicaid enrollment by sex and age.

**Table 4.4 Total Medicaid Enrollment by Sex and Age**

Total Medicaid Enrollment 2013 – 2015					
Sex	Age	2013	2014	2015	% Change
F	0–3	10,097	9,893	11,026	9.20%
F	4–17	34,332	36,313	36,984	7.72%
F	18–44	53,793	114,578	121,181	125.27%
F	45–64	37,555	69,078	74,297	97.84%
F	65+	24,673	31,549	33,897	37.38%
M	0–3	10,571	10,485	11,537	9.14%
M	4–17	38,441	40,715	40,933	6.48%
M	18–44	32,681	93,850	104,946	221.12%
M	45–64	30,457	59,544	65,591	115.36%
M	65+	11,077	15,301	16,709	50.84%
<b>Total</b>		<b>283,677</b>	<b>481,306</b>	<b>517,101</b>	<b>82.29%</b>

As expected, West Virginia saw an increase in the number of Medicaid members across each county in West Virginia between the calendar years 2013–2015. The increase in the 18–64 age category across all the counties is largely attributed to the State’s decision to expand their Medicaid population in 2013 in line with the ACA.

For detailed statistics on Medicaid member enrollment by county from 2013–2015, please refer to **Table 4.5 Total Medicaid Enrollment by County**.

**Table 4.5 Total Medicaid Enrollment by County**

Total Medicaid Enrollment by County				
County	2013	2014	2015	% Change
JEFFERSON	4,435	9,122	9,924	123.77%
PENDLETON	914	1,813	1,946	112.91%
MORGAN	1,935	3,830	4,024	107.96%
POCAHONTAS	1,202	2,328	2,487	106.91%
MONONGALIA	6,960	13,300	14,276	105.11%
TYLER	1,061	1,995	2,166	104.15%
TUCKER	836	1,599	1,692	102.39%
UPSHUR	3,481	6,295	6,973	100.32%
DODDRIDGE	988	1,720	1,975	99.90%
BERKELEY	12,252	22,492	24,478	99.79%

Total Medicaid Enrollment by County				
County	2013	2014	2015	% Change
GRANT	1,538	2,956	3,030	97.01%
KANAWHA	27,039	47,894	52,902	95.65%
HARDY	2,025	3,693	3,957	95.41%
HANCOCK	3,714	6,594	7,224	94.51%
PRESTON	4,144	7,531	7,998	93.00%
HAMPSHIRE	3,141	5,610	6,017	91.56%
MARSHALL	3,899	6,874	7,448	91.02%
RALEIGH	12,831	22,625	24,355	89.81%
BARBOUR	2,588	4,506	4,911	89.76%
LEWIS	2,746	4,751	5,188	88.93%
PUTNAM	5,407	9,394	10,168	88.05%
PLEASANTS	905	1,491	1,699	87.73%
GILMER	1,001	1,729	1,879	87.71%
OHIO	5,481	9,982	10,277	87.50%
TAYLOR	2,268	3,957	4,238	86.86%
LOGAN	7,702	13,409	14,380	86.70%
MONROE	1,768	3,279	3,300	86.65%
NICHOLAS	4,715	8,245	8,799	86.62%
JACKSON	4,117	7,019	7,618	85.04%
HARRISON	9,068	15,435	16,766	84.89%
WETZEL	2,560	4,502	4,692	83.28%
MARION	7,682	12,851	14,051	82.91%
RANDOLPH	4,680	7,944	8,530	82.26%
BRAXTON	2,606	4,366	4,734	81.66%
BROOKE	2,593	4,407	4,691	80.91%
BOONE	4,813	7,676	8,677	80.28%
CLAY	2,224	3,789	4,004	80.04%
MINERAL	3,258	5,694	5,857	79.77%
GREENBRIER	5,735	9,807	10,289	79.41%
ROANE	2,926	4,928	5,209	78.02%

Total Medicaid Enrollment by County				
County	2013	2014	2015	% Change
CABELL	18,589	30,102	32,843	76.68%
MERCER	12,852	21,302	22,662	76.33%
WIRT	1,047	1,723	1,843	76.03%
WOOD	13,561	21,982	23,807	75.55%
CALHOUN	1,577	2,611	2,752	74.51%
WYOMING	4,742	7,908	8,233	73.62%
RITCHIE	1,580	2,537	2,706	71.27%
SUMMERS	2,463	3,970	4,166	69.14%
FAYETTE	8,978	14,372	15,144	68.68%
LINCOLN	5,024	8,024	8,462	68.43%
MASON	4,421	6,887	7,395	67.27%
MINGO	7,016	10,906	11,596	65.28%
WEBSTER	2,375	3,689	3,851	62.15%
WAYNE	9,770	14,424	15,108	54.64%
MCDOWELL	6,471	9,576	9,924	53.36%
<b>Grand Total</b>	<b>283,677</b>	<b>481,309</b>	<b>517,125</b>	<b>82.29%</b>

In addition to West Virginia experiencing an overall increase in Medicaid enrollment, largely due to the addition of the Medicaid expansion population, the State Medicaid FFS population decreased due to the transition of services from the State's FFS healthcare delivery model to the Managed Care Organizations (MCO) healthcare delivery model.

Please refer to **Table 1.1 Member Enrollment by** for more information on the number of Medicaid members who have transitioned from FFS to WVMHT.

To further illustrate Medicaid FFS members' eligibility across the State during the calendar years of 2013 – 2015, please refer to the breakdown of members by their respective eligibility categories in **Table 4.6**.

**Table 4.6 Enrollees by Member Eligibility Category**

Member Eligibility Category, 2013 – 2015				
Eligibility Category	2013	2014	2015	% Change
Former Foster Children	4	57	102	2,450.00%
Modified Adjusted Gross Income (MAGI) Adult	12,668	195,721	229,738	1,713.53%

Member Eligibility Category, 2013 – 2015				
Eligibility Category	2013	2014	2015	% Change
Extended Medicaid	73	515	1,090	1,393.15%
Childrens Medicaid	10,040	66,519	74,836	645.38%
MAGI Newborn	381	1,944	1,885	394.75%
MAGI Pregnancy	2,210	10,265	9,289	320.32%
MAGI Parent/Caretaker	7,632	28,311	26,450	246.57%
Illegal/Ineligible Alien	20	187	66	230.00%
QMB	27,549	41,138	87,242	216.68%
Foster Children	14,236	15,268	16,849	18.35%
Nursing Home	1,017	1,074	1,082	6.39%
Supplemental Security Income (SSI)	102,939	101,084	99,220	-3.61%
Medicaid Buy-in	1,044	830	831	-20.40%
Breast and Cervical Cancer Program	597	473	388	-35.01%
Medically Needy	6,179	2,201	1,191	-80.73%
Financially Needy	96,365	25,731	14,731	-84.71%
Aid to Families with Dependent Children (AFDC)	13,203	2,394	178	-98.65%
Medicare Part B Premiums	0	5,874	7,275	N/A*
Hospital-Based Presumptive Eligibility	0	7,542	7,250	N/A*
MAGI Spousal Support	0	0	1	N/A*
<b>Grand Total</b>	<b>296,157</b>	<b>507,128</b>	<b>538,556</b>	<b>81.85%</b>

*Note: Total member eligibility counts may differ from other member counts due to members with multiple eligibilities.*

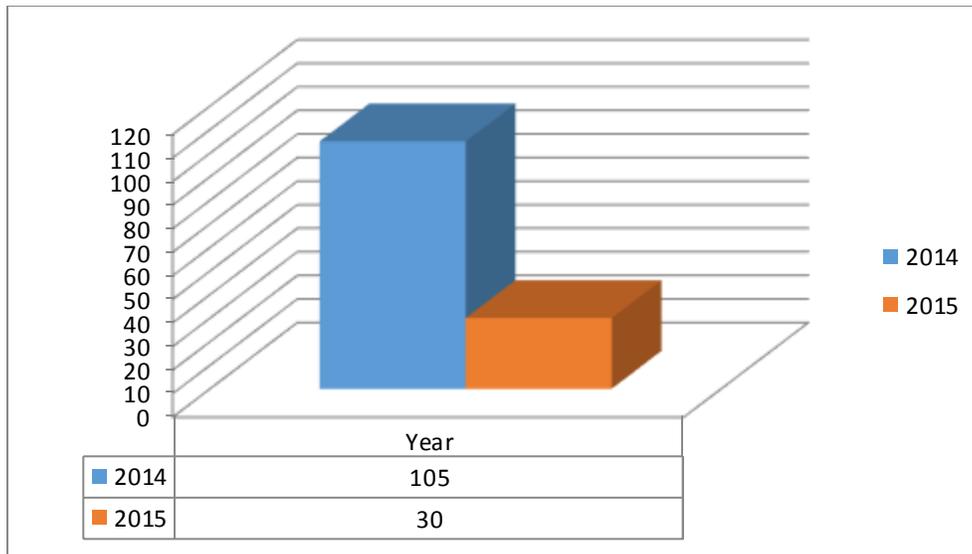
*\*There were no members with this form of eligibility in 2013; therefore, the percentage increase cannot be calculated.*

### 4.2.3 Beneficiary Requests for Assistance

West Virginia's MMIS fiscal agent receives and responds to calls from West Virginia Medicaid members regarding a variety of questions and/or concerns, ranging from eligibility to Medicaid ID card assistance. In addition to these questions, the fiscal agent is available to respond to requests for location information for Medicaid providers within the West Virginia Medicaid network.

As depicted in **Figure 4.2 Requests for Assistance Locating a Primary Care Provider**, the MMIS fiscal agent received approximately 105 requests for assistance in locating a primary care provider during the 2014 calendar year, while during 2015, this request dropped by over 70%.

**Figure 4.2 Requests for Assistance Locating a Primary Care Provider**



The State believes the decrease in call volume may be attributed to an increased presence by Medicaid provider field representatives and field offices across the State, as well as the transition of members from the Medicaid FFS program over to the State’s managed care program, WVMHT.

In addition to the above analysis, the State plans to make available the surveys depicted in **Appendix C: Access Monitoring Survey – Members** and **Appendix D: Access Monitoring Survey – Providers**.

#### **4.2.4 Beneficiary Perceptions of ATC**

In the absence of FFS CAHPS data, the State utilized both member and provider counts across West Virginia to identify a Medicaid member per provider count across West Virginia counties during the 2013 – 2015 calendar years. This count represents the total number of eligible Medicaid members per enrolled providers in a given West Virginian county, and will be used to help the State conclude potential beneficiary perceptions on ATC. This analysis did not incorporate neighboring Commonwealths.

Findings indicate that nearly all West Virginia counties experienced an increased number of Medicaid enrollees per Medicaid provider. This was anticipated, since there was over an 80% increase in the enrollee population. The largest increase was in Pleasants County, where Medicaid enrollees per Medicaid provider counts rose by more than 140 members per provider.

For more information on eligible Medicaid members per provider in counties across all service categories during the 2013 – 2015 calendar years, please refer to **Table 4.7 Medicaid Members per Provider (All Categories), 2013 – 2015**.

**Table 4.7 Medicaid Members per Provider (All Categories), 2013 – 2015**

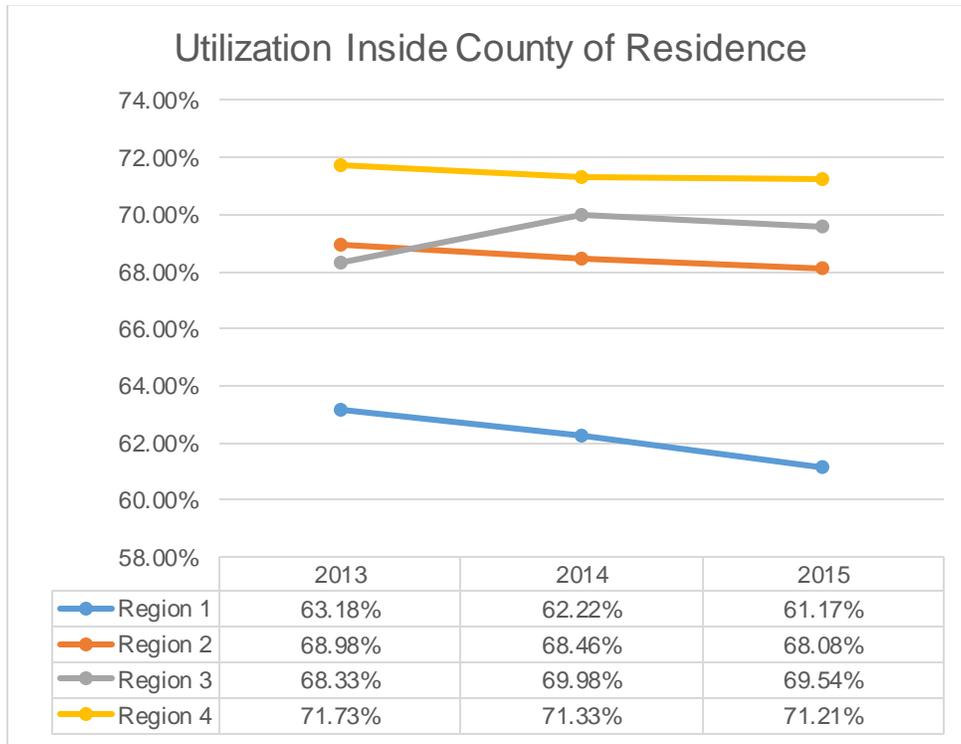
<b>Medicaid Members per Provider (All Categories), 2013 –2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
PLEASANTS	100.6	149.1	242.7	141.37%
RITCHIE	87.8	149.2	208.2	137.14%
DODDRIDGE	123.5	215.0	282.1	128.46%
BROOKE	39.3	64.8	85.3	117.09%
TYLER	50.5	95.0	108.3	114.35%
PENDLETON	60.9	139.5	129.7	112.91%
WETZEL	48.3	90.0	102.0	111.17%
UPSHUR	47.7	87.4	96.8	103.10%
MARSHALL	56.5	110.9	114.6	102.78%
NICHOLAS	58.9	109.9	118.9	101.75%
LOGAN	58.8	103.1	116.9	98.85%
HAMPSHIRE	98.2	181.0	194.1	97.74%
BARBOUR	80.9	145.4	158.4	95.88%
MINGO	143.2	227.2	269.7	88.34%
HARDY	88.0	147.7	164.9	87.27%
TUCKER	69.7	123.0	130.2	86.82%
POCAHONTAS	48.1	97.0	88.8	84.74%
JEFFERSON	46.7	81.4	84.8	81.69%
KANAWHA	21.5	36.3	38.9	81.12%
MARION	44.1	73.0	79.8	80.83%
CLAY	96.7	164.7	174.1	80.04%
WAYNE	222.0	327.8	397.6	79.05%
JACKSON	68.6	115.1	120.9	76.23%
OHIO	14.7	25.1	26.0	76.14%
GREENBRIER	33.7	56.0	59.1	75.28%
RANDOLPH	38.0	64.6	66.6	75.15%
LINCOLN	167.5	258.8	291.8	74.24%
HARRISON	27.9	44.9	48.5	73.67%
MERCER	43.1	65.7	74.5	72.85%

<b>Medicaid Members per Provider (All Categories), 2013 –2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
MONONGALIA	8.5	15.0	14.7	72.76%
MORGAN	84.1	182.4	143.7	70.82%
WOOD	34.3	53.9	58.5	70.38%
MONROE	93.1	182.2	157.1	68.88%
WYOMING	163.5	239.6	274.4	67.83%
MINERAL	66.5	103.5	110.5	66.21%
GILMER	143.0	345.8	234.9	64.25%
BERKELEY	54.0	90.3	88.4	63.73%
ROANE	91.4	144.9	148.8	62.77%
PRESTON	78.2	144.8	127.0	62.37%
TAYLOR	73.2	123.7	117.7	60.91%
FAYETTE	73.0	117.8	117.4	60.83%
CABELL	24.5	36.8	39.1	59.24%
RALEIGH	36.1	55.2	56.6	56.71%
PUTNAM	52.5	87.0	81.3	54.96%
BRAXTON	93.1	132.3	143.5	54.13%
LEWIS	51.8	79.2	79.8	54.05%
HANCOCK	39.1	59.9	60.2	53.98%
MASON	78.9	112.9	117.4	48.68%
BOONE	145.8	213.2	197.2	35.21%
MCDOWELL	196.1	273.6	261.2	33.18%
GRANT	46.6	86.9	61.8	32.68%
WIRT	174.5	215.4	230.4	32.02%
SUMMERS	175.9	248.1	231.4	31.56%
CALHOUN	175.2	237.4	229.3	30.88%
WEBSTER	169.6	245.9	137.5	-18.93%
<b>Average</b>	<b>82.0</b>	<b>134.1</b>	<b>138.1</b>	<b>68.45%</b>

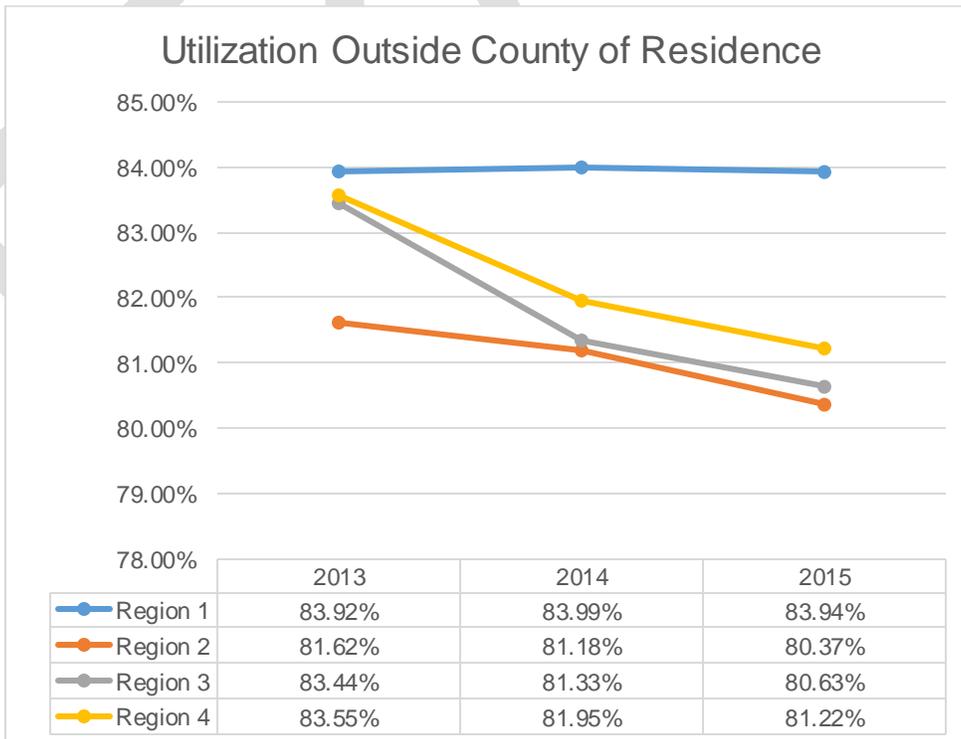
As depicted in the following figures, West Virginia experienced a lower percentage of members utilizing services from providers within their counties of residence in 2015 than in 2013. The State also experienced lower utilization of services outside members' counties of residence.

Please refer to **Figure 4.3 Utilization Inside County of Residence** and **Figure 4.4 Utilization Outside County of Residence** for more information.

**Figure 4.3 Utilization Inside County of Residence**



**Figure 4.4 Utilization Outside County of Residence**



Regions 2, 3, and 4 experienced decreases in members utilization of services outside their counties of residence, while Region 1 remained relatively stable. Likewise, beneficiaries in Region 1 utilized services inside their counties of residence at a lower rate in 2015 than in 2013. For the interpretation of the above charts, it is important to note that members may utilize services both inside and outside of their counties of residence.

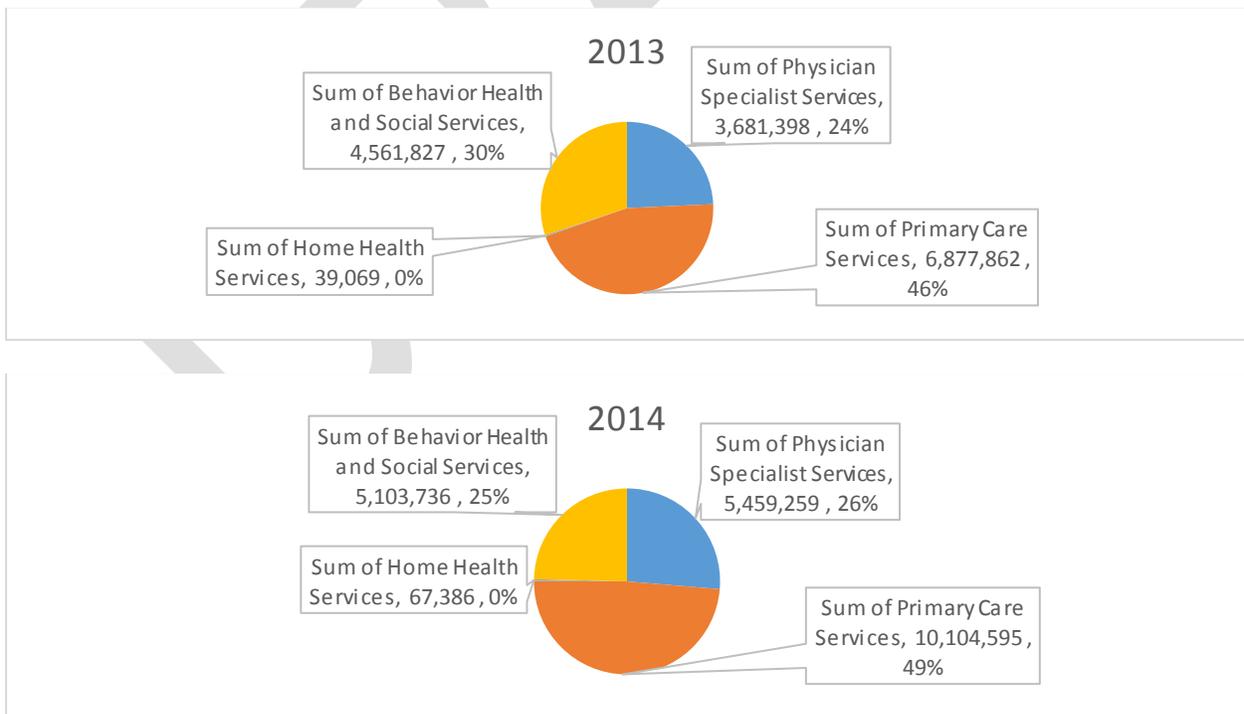
#### 4.2.5 Beneficiary Utilization of Services

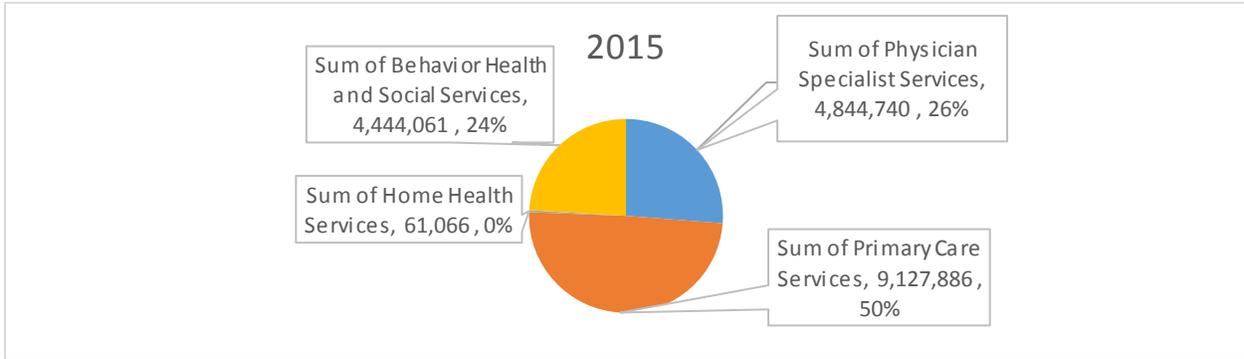
To quantify utilization of services by West Virginian members across ATC categories, member claim counts were examined across age and service categories.

Data represented in this section and related **Section 3.0 Data Findings and Analysis** subsections does not include those members utilizing services within the Physician Assured Access System (PAAS) and premium assistance programs.

**Figure 4.5 Service Utilization Across Service Categories (2013 – 2015)** below depicts the breakdown of service utilization across service categories for finalized claims in 2013, 2014, and 2015. Not included in the charts are claims for other services, which made up roughly 50% of all finalized claims in both years. Utilization of primary care services and specialist services (which includes dental services) appears to have increased proportionally from 2013 to 2015. Given the timeframe at which this occurred, and the concurrent increase of the MAGI Adult or HealthBridge population, as can be seen in **4.2.2 Beneficiary Eligibility, Gender, and Age Characteristics**, the State believes this was likely due to the expansion of the State’s Medicaid population in line with the ACA.

**Figure 4.5 Service Utilization Across Service Categories (2013 – 2015)**



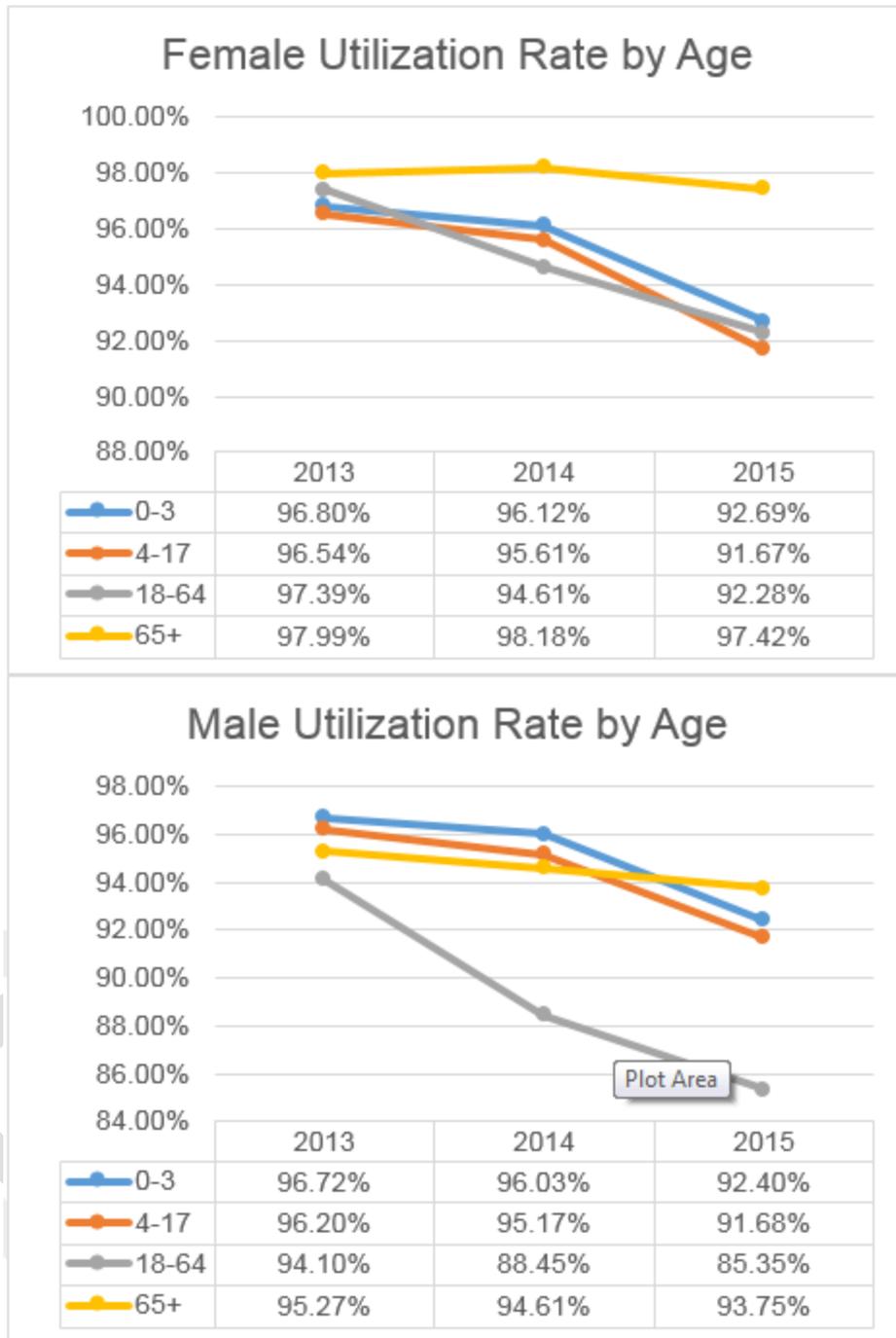


Throughout the 2013 – 2015 time period, the State also experienced an average decline in the rate of members’ utilization of ATC services across all age categories. Although the decline was experienced across all age categories, it was most visible among men and women ages 18–64.

The following figures offer more information on female and male utilization rates by age category across ATC service categories:

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Figure 4.6 Female and Male Utilization Rates by Age Category



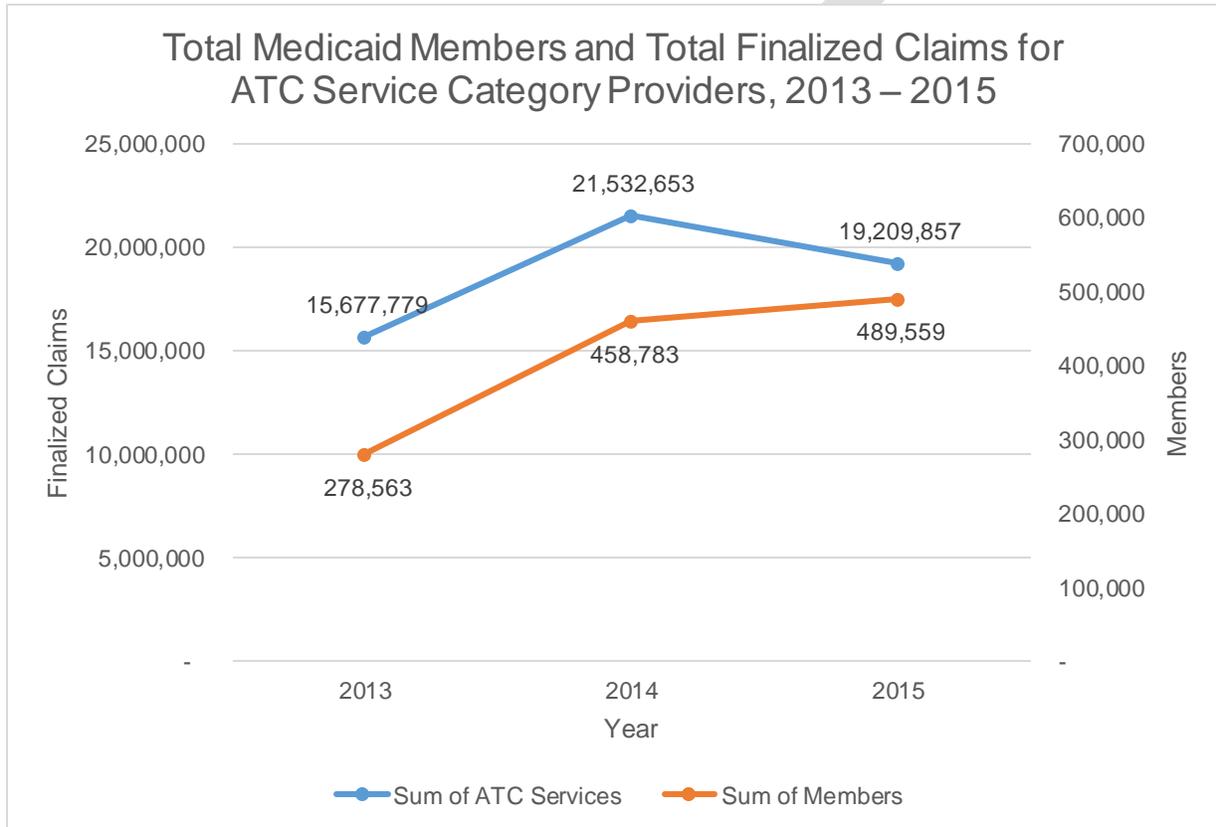
The decline in per-member service utilization may be partially explained by the increase in enrollees across the 18–64 age range as a result of ACA Medicaid expansion. This was also a similar finding in **4.2.1 Provider Enrollment**, where enrollment for men ages 18–64 increased by over 450% between 2013 and 2015. Given the expanded 18–64 year old population, as well as the expansion that occurred within the MAGI adult category, the State believes the decline

was a result of the addition of relatively healthy people who tend to utilize services less frequently.

Utilization, as measured by total finalized claims for ATC service category providers, increased sharply from 2013 to 2014, but then declined from 2014 to 2015. The State believes this significant increase can be attributed to the ACA's rate increase for primary care providers.

Please refer to **Figure 4.7 Total Medicaid Members and Total Finalized Claims for ATC Service Category Providers** for more information.

**Figure 4.7 Total Medicaid Members and Total Finalized Claims for ATC Service Category Providers**



#### 4.2.6 Medicaid, Medicare, and Other Payer Rates

In support of comparison of Medicaid, Medicare, and other payer rates, West Virginia has provided observations of three elements of West Virginia's healthcare system: Capitation, Medicare, and FFS.

Capitation pertains to the population-based method of funding Medicaid services where compensation is calculated, in advance, based on a specific, defined population on a per patient basis, regardless of health status.

Medicare pertains to a population of individuals over the age of 65, youth with disabilities, and people with end-stage renal disease.

FFS Medicaid, on the other hand, allows physicians to be compensated based on an established rate for each individual service provided to a given patient.

A high-level summary of capitated Medicaid rates, and Medicare-to-Medicaid fees, has been provided in **Table 4.8** and **Table 4.9** below.

**Table 4.8 West Virginia Medicaid Capitation Rates (Roll-up of All 55 Counties by Age and Gender)**

West Virginia Medicaid Capitation Rates September 2015 – May 2016 (Roll-up of All 55 Counties by Age and Gender)											
Avg Delivery	Avg < 1 yr	Avg 1 yr	Avg 2-14	Avg 15-19 M	Avg 15-19 F	Avg 20-29 M	Avg 20-29 F	Avg 30-39 M	Avg 30-39 F	Avg 40+	Sum of all Averages
\$4,555	\$906	\$340	\$334	\$399	\$527	\$265	\$338	\$306	\$338	\$402	\$8,710

**Table 4.8**, as shown above, provides Medicaid capitation rates, averaged across all 55 West Virginia counties, for a broad spectrum of age groups that are, in part, differentiated by gender.

To that end, the above data table illustrates, for example, that West Virginia service providers participating in the West Virginia capitation program are paid, on average, \$399 for a 15–19 year old male and \$527 for a female within the same age group.

Regarding Medicare-to-Medicaid fees, as reported by the Urban Institute, an economic and social policy research organization located in Washington, DC, “The Medicaid-to-Medicare fee index measures Medicaid physician fees relative to Medicare fees. The Medicaid data is based on surveys sent by the Urban Institute to the 49 states and the District of Columbia that have a FFS component in their Medicaid programs (only Tennessee does not). These fees represent only those payments made under FFS Medicaid. The Medicare-to-Medicaid fee index is computed by taking the ratio of the Medicaid fee for each service in each state to the Medicare fee for the same services. Medicare fees are calculated using the 2014 relative value units (RVU), geographic adjusters, and conversion factor.”

**Table 4.9 Medicaid-to-Medicare Fee Index – 2014**

Medicaid-to-Medicare Fee Index – 2014			
Location	All Services	Primary Care	Other Services
United States	0.66	0.59	0.74
West Virginia	0.79	0.74	0.74

**Table 4.9**, as shown above, provides a high-level perspective, illustrating Medicaid physician fees relative to Medicare fees for West Virginia and the United States as a whole. Numbers greater than 1 show that Medicare fees are lower than Medicaid fees within that category, and, correspondingly, numbers less than 1 show that Medicare fees are higher than Medicaid fees. It also shows that West Virginia’s Medicaid rates are higher, on average, than the national Medicaid payment average.

For example, West Virginia’s “All Services” category has a fee index of .79, meaning that West Virginia’s Medicaid fees are 79% of the Medicare fees, or, alternatively stated, Medicare Fees are 21% higher than West Virginia Medicaid fees. Nationally, the Medicaid rate is 66%, which means West Virginia’s 79% is 13% higher than the national average.

As West Virginia continues ATC data collection and analysis, further permutations showing more detailed perspectives of West Virginia’s Top 10 utilized Current Procedural Terminology (CPT) codes, and their associated fees (averaged across all facilities), for 2013, 2014, and 2015 may also be incorporated into the State’s approach to monitoring access to FFS categories specific to this ATC analysis.

### 4.3 Primary Care Services

Primary care services for the State consist of nurse practitioners, FQHCs, general and family practice, emergency medicine, internal medicine, pediatricians, rural health clinics, adult nurse practitioners, physician assistants, physicians, and multi-provider type/specialty groups. The following sections describe overall ATC data measures and findings across the primary care services category.

#### 4.3.1 Provider Enrollment

Across the 2013 – 2015 calendar years, West Virginia experienced an overall 12.08% increase in provider enrollment across primary care services. Findings indicate that primary care services are present for members to access in their respective counties.

For a more detailed analysis on primary care services across counties in West Virginia during calendar years 2013 – 2015, please refer to **Table 4.10 Number of Enrolled Provider by County for Primary Care Services.**

**Table 4.10 Number of Enrolled Provider by County for Primary Care Services**

Primary Care Services: Number of Enrolled Providers by County				
County/Commonwealth	2013	2014	2015	% Change
RITCHIE	13.00	11.00	9.00	-30.77%
PENNSYLVANIA (COMMONWEALTH)	538.00	525.00	453.00	-15.80%
MINGO	27.00	25.00	23.00	-14.81%
BROOKE	30.00	29.00	26.00	-13.33%
WETZEL	30.00	26.00	26.00	-13.33%
CLAY	18.00	17.00	16.00	-11.11%
HARDY	15.00	15.00	14.00	-6.67%
LOGAN	76.00	74.00	71.00	-6.58%
DODDRIDGE	5.00	5.00	5.00	0.00%
GREENBRIER	89.00	92.00	89.00	0.00%

Primary Care Services: Number of Enrolled Providers by County				
County/Commonwealth	2013	2014	2015	% Change
LINCOLN	20.00	19.00	20.00	0.00%
NICHOLAS	39.00	38.00	39.00	0.00%
PENDLETON	8.00	8.00	8.00	0.00%
PLEASANTS	4.00	5.00	4.00	0.00%
WYOMING	14.00	15.00	14.00	0.00%
UPSHUR	42.00	44.00	43.00	2.38%
MINERAL	24.00	26.00	25.00	4.17%
KENTUCKY (COMMONWEALTH)	281.00	287.00	293.00	4.27%
POCAHONTAS	20.00	19.00	21.00	5.00%
FAYETTE	70.00	71.00	74.00	5.71%
MERCER	137.00	160.00	145.00	5.84%
MARION	72.00	76.00	77.00	6.94%
RANDOLPH	57.00	58.00	61.00	7.02%
MCDOWELL	26.00	28.00	28.00	7.69%
HANCOCK	51.00	51.00	55.00	7.84%
BARBOUR	22.00	23.00	24.00	9.09%
WOOD	163.00	176.00	180.00	10.43%
MARSHALL	27.00	28.00	30.00	11.11%
VIRGINIA (COMMONWEALTH)	626.00	683.00	707.00	12.94%
MARYLAND (COMMONWEALTH)	222.00	248.00	253.00	13.96%
TYLER	14.00	14.00	16.00	14.29%
KANAWHA	482.00	530.00	558.00	15.77%
CABELL	329.00	366.00	382.00	16.11%
OHIO (COMMONWEALTH)	839.00	918.00	976.00	16.33%
MONROE	12.00	12.00	14.00	16.67%
MORGAN	18.00	16.00	21.00	16.67%
SUMMERS	12.00	14.00	14.00	16.67%
TUCKER	6.00	7.00	7.00	16.67%
PRESTON	35.00	35.00	41.00	17.14%
JACKSON	29.00	34.00	34.00	17.24%

Primary Care Services: Number of Enrolled Providers by County				
County/Commonwealth	2013	2014	2015	% Change
HARRISON	125.00	141.00	149.00	19.20%
BRAXTON	20.00	25.00	24.00	20.00%
GILMER	5.00	3.00	6.00	20.00%
WIRT	5.00	5.00	6.00	20.00%
PUTNAM	65.00	70.00	79.00	21.54%
OHIO	131.00	157.00	160.00	22.14%
RALEIGH	162.00	193.00	199.00	22.84%
WAYNE	13.00	17.00	16.00	23.08%
MASON	30.00	31.00	37.00	23.33%
ROANE	19.00	20.00	24.00	26.32%
TAYLOR	19.00	20.00	24.00	26.32%
BERKELEY	100.00	117.00	128.00	28.00%
CALHOUN	7.00	7.00	9.00	28.57%
HAMPSHIRE	12.00	15.00	16.00	33.33%
JEFFERSON	57.00	69.00	76.00	33.33%
MONONGALIA	332.00	374.00	443.00	33.43%
BOONE	22.00	26.00	31.00	40.91%
LEWIS	21.00	26.00	31.00	47.62%
GRANT	14.00	17.00	23.00	64.29%
WEBSTER	11.00	13.00	25.00	127.27%
<b>Grand Total</b>	<b>5,712</b>	<b>6,174</b>	<b>6,400</b>	<b>12.08%</b>
<b>Total Averages</b>	<b>95.20</b>	<b>102.90</b>	<b>106.70</b>	<b>12.08%</b>

As displayed in **Table 4.11 Number of Enrolled Primary Care Providers by Provider Type**, during the 2013 – 2015 calendar years, West Virginia experienced an increase in primary care services providers of over 12%. Through 2014, there was a push to increase primary care services provider enrollment, and the extent of the program’s success is reflected in the increases shown in **Table 4.10 Number of Enrolled Primary Care Providers by County**. As shown below, the majority of that increase came from provider groups, nurse practitioners, and physician assistants. In fact, providers enrolled as physicians decreased slightly from 2013 – 2015.

For more information on the increase in provider types across Primary Care Services, please refer to **Table 4.11 Number of Enrolled Primary Care Providers by Provider Type**, which

includes the number of enrolled Primary Care Service providers by their corresponding provider type.

**Table 4.11 Number of Enrolled Primary Care Providers by Provider Type**

Primary Care Services: Number of Enrolled Providers by Provider Type				
Provider Type	2013	2014	2015	% Change
SOCIAL WORKER (PHYSICIAN ASSISTANT)	1	1	0	-100.00%
RURAL HEALTH CLINIC	56	55	55	-1.79%
PHYSICIAN	4903	4987	4836	-1.37%
FQHC	176	185	206	17.05%
NURSE PRACTITIONER	730	921	1136	55.62%
PHYSICIAN ASSISTANT	49	95	117	138.78%
GROUP PROVIDER	105	237	272	159.05%
NON-PHYSICIAN PRACTITIONER	1	18	78	7700.00%
HEALTH DEPARTMENTS	0	0	1	N/A*
<b>Grand Total</b>	<b>6,021</b>	<b>6,499</b>	<b>6,701</b>	<b>11.29%</b>
<b>Total Average</b>	<b>669.00</b>	<b>722.11</b>	<b>744.56</b>	<b>11.29%</b>
<i>*The percent in change from the years 2013 – 2015 could not be calculated due to the absence of providers in 2013.</i>				

### 4.3.2 Beneficiary Perceptions of ATC

As depicted in **Table 4.12** below, the number of enrolled members per enrolled primary services provider increased markedly from 2013 – 2015. Much of the increase appears to have come from 2013 – 2014, when Medicaid expansion was implemented. Despite the enrollment of additional primary care providers as described above, the number of enrolled members per enrolled primary care services provider increased by as much as 147% at the county level. Such increases of members per provider could result in fewer providers taking new Medicaid patients. Through monthly, quarterly, and yearly MMIS reporting and the provider and member surveys to be enacted upon CMS approval of the Access Monitoring Plan, the BMS will continue to monitor the availability of primary care providers to Medicaid enrollees.

For more information on the State’s ongoing access monitoring methodology, please refer to **Section 5.1 Ongoing Monitoring of ATC**, and for more information on the State’s provider and member surveys, please refer to **Appendix C: Access Monitoring Survey – Members** and **Appendix D: Access Monitoring Survey – Providers**.

**Table 4.12 Medicaid Members per Primary Care Services Provider, 2013 – 2015**

<b>Medicaid Members per Primary Care Services Provider, 2013 – 2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
BARBOUR	117.6	195.9	204.6	73.9%
BERKELEY	122.5	189.0	186.9	52.5%
BOONE	209.3	295.2	271.2	29.6%
BRAXTON	130.3	174.6	189.4	45.3%
BROOKE	81.0	129.6	180.4	122.7%
CABELL	55.7	80.9	84.2	51.3%
CALHOUN	225.3	373.0	305.8	35.7%
CLAY	123.6	222.9	250.3	102.5%
DODDRIDGE	197.6	344.0	395.0	99.9%
FAYETTE	128.3	202.4	196.7	53.3%
GILMER	200.2	576.3	313.2	56.4%
GRANT	109.9	173.9	131.7	19.9%
GREENBRIER	63.0	106.6	109.5	73.7%
HAMPSHIRE	261.8	374.0	376.1	43.7%
HANCOCK	70.1	117.8	122.4	74.7%
HARDY	135.0	246.2	282.6	109.4%
HARRISON	72.0	107.9	108.9	51.3%
JACKSON	137.2	212.7	217.7	58.6%
JEFFERSON	77.8	132.2	130.6	67.8%
KANAWHA	55.2	88.9	92.3	67.3%
LEWIS	130.8	182.7	152.6	16.7%
LINCOLN	251.2	422.3	423.1	68.4%
LOGAN	98.7	181.2	199.7	102.3%
MARION	103.8	164.8	175.6	69.2%
MARSHALL	134.4	237.0	225.7	67.9%
MASON	142.6	215.2	199.9	40.1%
MCDOWELL	239.7	342.0	342.2	42.8%
MERCER	90.5	131.5	147.2	62.6%
MINERAL	135.8	219.0	234.3	72.6%

<b>Medicaid Members per Primary Care Services Provider, 2013 – 2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
MINGO	269.8	419.5	527.1	95.3%
MONONGALIA	21.0	35.4	32.1	52.6%
MONROE	136.0	273.3	235.7	73.3%
MORGAN	107.5	239.4	191.6	78.3%
NICHOLAS	117.9	211.4	214.6	82.1%
OHIO	40.6	60.1	62.3	53.4%
PENDLETON	114.3	226.6	243.3	112.9%
PLEASANTS	181.0	248.5	339.8	87.7%
POCAHONTAS	60.1	116.4	113.0	88.1%
PRESTON	115.1	215.2	190.4	65.4%
PUTNAM	84.5	132.3	125.5	48.6%
RALEIGH	78.7	115.4	117.7	49.5%
RANDOLPH	82.1	134.6	135.4	64.9%
RITCHIE	121.5	230.6	300.7	147.4%
ROANE	154.0	246.4	226.5	47.1%
SUMMERS	205.3	283.6	297.6	45.0%
TAYLOR	113.4	197.9	169.5	49.5%
TUCKER	139.3	228.4	241.7	73.5%
TYLER	75.8	133.0	135.4	78.6%
UPSHUR	82.9	146.4	158.5	91.2%
WAYNE	751.5	848.5	944.3	25.6%
WEBSTER	215.9	283.8	148.1	-31.4%
WETZEL	85.3	173.2	180.5	111.5%
WIRT	209.4	344.6	307.2	46.7%
WOOD	80.7	120.1	129.4	60.3%
WYOMING	316.1	494.3	548.9	73.6%
<b>Average</b>	<b>87.2</b>	<b>134.6</b>	<b>135.5</b>	<b>55.4%</b>

The Health Resources and Services Administration (HRSA) defines a Health Professional Shortage Area (HPSA) for a given population group as an area in which the ratio of the served population to primary care providers is at least 3,000:1. All counties have ratios of members to primary care providers of well under 3,000:1, as shown above; however, in general, providers

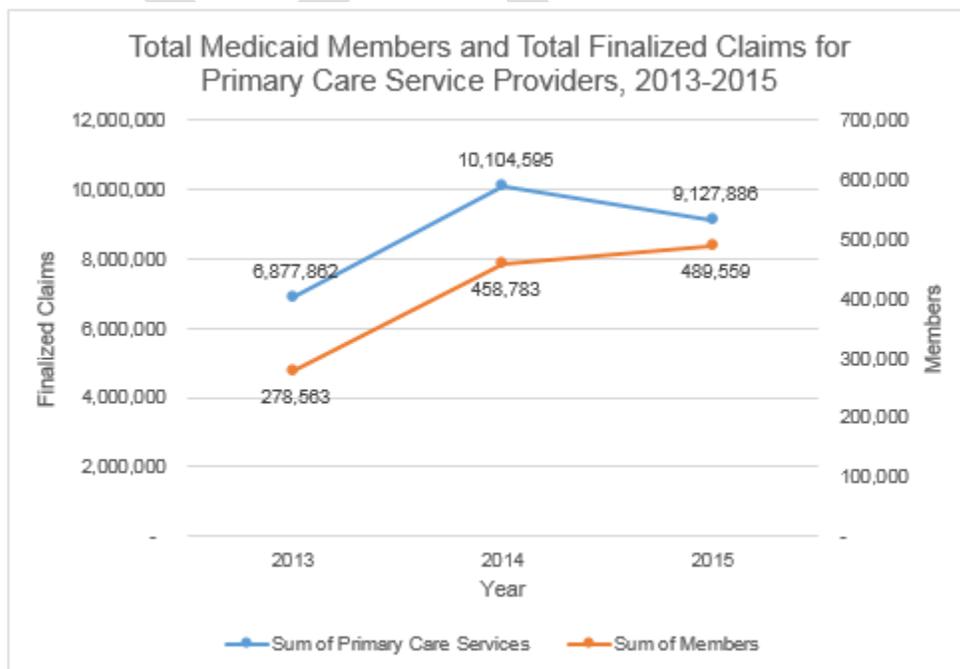
do not only see Medicaid patients—they perform services for a variety of patients, including Medicaid enrollees, Medicare enrollees, and individuals covered under a private insurance plan. Based on the overall ratio of members to enrolled primary care providers for the State (135.5), the State as whole would qualify as an HPSA if Medicaid enrollees constituted, on average, less than 4.5% of an enrolled provider’s patient roster. That percentage varies from 31.5% in Wayne County to 1.1% in Monongalia County.

Given that Medicaid enrollees made up 27.9% of West Virginia’s population in 2015, the availability of physicians for Medicaid patients should be sufficient to avoid exceeding the HPSA threshold. This does not preclude more limited areas of the State from being classified as HPSAs. Indeed, the Kaiser Family Foundation lists 105 total primary service care HPSA designations, requiring 26 additional primary care providers to alleviate concerns. In relation to the rest of the country, West Virginia ranks fifth in terms of percentage of overall need met. However, especially in areas like Wyoming County, BMS will continue to survey and examine the ratio of enrolled providers to members’ data to gather information about provider and member experiences and perceptions.

#### 4.3.3 Beneficiary Utilization of Services

As measured by claims per member, **Figure 4.8 Total Medicaid Members and Finalized Claims by Primary Care Service Providers** below depicts the demand for primary care services in counties across West Virginia. The top 10 counties, as well as the statewide average, are displayed in **Table 4.13**. These counties display a higher than statewide average utilization rate of primary care services, a difference that may be attributable to county demographics as they relate to population and/or age. Based on the high rate of utilization in these counties, BMS will continue to monitor the availability of primary care services in these counties.

**Figure 4.8 Total Medicaid Members and Total Finalized Claims by Primary Care Service Providers**



**Table 4.13 Primary Care Services Claims per Member (Top 10 Counties)**

Primary Care Services Claims per Member (Top 10 Counties)				
Top 10 County	2013	2014	2015	% Change
RALEIGH	33.14	27.37	23.48	-29.15%
GREENBRIER	32.65	28.36	23.15	-29.10%
POCAHONTAS	29.33	23.68	21.39	-27.07%
MONROE	29.58	24.54	21.62	-26.91%
BROOKE	30.54	26.16	22.66	-25.80%
SUMMERS	32.49	28.98	24.90	-23.36%
FAYETTE	31.50	29.16	24.26	-22.98%
MARION	29.03	31.05	23.49	-19.08%
WYOMING	30.46	28.64	25.75	-15.46%
HARDY	23.46	25.40	24.38	3.92%
<b>Average of Top 10 Counties</b>	<b>30.22</b>	<b>27.33</b>	<b>23.51</b>	<b>-22.20%</b>
<b>Average of All Counties</b>	<b>24.36</b>	<b>21.59</b>	<b>18.42</b>	<b>-24.38%</b>

## 4.4 Physician Specialist Services

### 4.4.1 Provider Enrollment

Table 4.14 describes the overall number of enrolled providers across West Virginia's Medicaid physician specialist services program throughout the calendar years 2013 – 2015. As represented in the below table, provider enrollment in the Physician Specialist Services program decreased during the 2013 – 2015 calendar years by roughly 180 providers.

**Table 4.14 Provider Enrollment Across Physician Specialist Services by County**

Physician Specialist Services: Number of Enrolled Providers by County				
County/Commonwealth	2013	2014	2015	% Change
DODDRIDGE	2.00	2.00	1.00	-50.00%
WAYNE	20.00	15.00	12.00	-40.00%
HAMPSHIRE	12.00	9.00	9.00	-25.00%
PLEASANTS	4.00	4.00	3.00	-25.00%
RITCHIE	4.00	5.00	3.00	-25.00%
PENNSYLVANIA (COMMONWEALTH)	1,445.00	1,424.00	1,114.00	-22.91%
BROOKE	29.00	27.00	23.00	-20.69%
LINCOLN	5.00	6.00	4.00	-20.00%

<b>Physician Specialist Services: Number of Enrolled Providers by County</b>				
<b>County/Commonwealth</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
NICHOLAS	27.00	25.00	22.00	-18.52%
MARSHALL	33.00	29.00	27.00	-18.18%
BARBOUR	6.00	5.00	5.00	-16.67%
UPSHUR	25.00	22.00	22.00	-12.00%
MINGO	18.00	18.00	16.00	-11.11%
WETZEL	18.00	18.00	16.00	-11.11%
MARION	84.00	78.00	75.00	-10.71%
ROANE	10.00	11.00	9.00	-10.00%
LOGAN	44.00	45.00	41.00	-6.82%
OHIO (COMMONWEALTH)	1,023.00	1,010.00	975.00	-4.69%
JACKSON	24.00	23.00	23.00	-4.17%
HARRISON	164.00	166.00	158.00	-3.66%
OHIO	202.00	195.00	195.00	-3.47%
MERCER	133.00	140.00	129.00	-3.01%
KENTUCKY (COMMONWEALTH)	395.00	418.00	386.00	-2.28%
BRAXTON	6.00	6.00	6.00	0.00%
GILMER	1.00	1.00	1.00	0.00%
MASON	24.00	27.00	24.00	0.00%
PENDLETON	6.00	5.00	6.00	0.00%
POCAHONTAS	5.00	4.00	5.00	0.00%
TUCKER	4.00	4.00	4.00	0.00%
TYLER	4.00	4.00	4.00	0.00%
WEBSTER	2.00	2.00	2.00	0.00%
WOOD	196.00	194.00	196.00	0.00%
GREENBRIER	69.00	73.00	71.00	2.90%
KANAWHA	686.00	699.00	711.00	3.64%
RANDOLPH	53.00	52.00	55.00	3.77%
LEWIS	24.00	26.00	25.00	4.17%
FAYETTE	46.00	49.00	48.00	4.35%
VIRGINIA (COMMONWEALTH)	792.00	788.00	829.00	4.67%

<b>Physician Specialist Services: Number of Enrolled Providers by County</b>				
<b>County/Commonwealth</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
CABELL	369.00	391.00	393.00	6.50%
MONONGALIA	437.00	465.00	472.00	8.01%
PUTNAM	30.00	31.00	33.00	10.00%
JEFFERSON	29.00	35.00	32.00	10.34%
BERKELEY	107.00	101.00	120.00	12.15%
TAYLOR	8.00	9.00	9.00	12.50%
MONROE	6.00	6.00	7.00	16.67%
RALEIGH	162.00	186.00	194.00	19.75%
MORGAN	5.00	5.00	6.00	20.00%
BOONE	9.00	9.00	11.00	22.22%
MINERAL	12.00	15.00	15.00	25.00%
MARYLAND (COMMONWEALTH)	190.00	201.00	238.00	25.26%
HARDY	7.00	8.00	9.00	28.57%
WYOMING	7.00	10.00	9.00	28.57%
CALHOUN	2.00	3.00	3.00	50.00%
CLAY	2.00	2.00	3.00	50.00%
GRANT	14.00	12.00	21.00	50.00%
PRESTON	12.00	13.00	18.00	50.00%
SUMMERS	2.00	2.00	3.00	50.00%
HANCOCK	33.00	43.00	52.00	57.58%
MCDOWELL	4.00	5.00	8.00	100.00%
<b>Grand Total</b>	<b>7,093.00</b>	<b>7,182.00</b>	<b>6,911.00</b>	<b>-2.57%</b>
<b>Total Averages</b>	<b>118.22</b>	<b>119.70</b>	<b>117.14</b>	<b>-0.91%</b>

Members in all counties during the years 2013 – 2015 had access to providers enrolled in the physician specialist services category of service in their respective counties, with the exception of Wirt County. Despite access to services across nearly all West Virginian counties, the State experienced an overall decrease in specialist services of 2.57% across the State from 2013. BMS will continue to monitor the overall decrease in physician specialist services to help ensure potential ATC deficiencies are mitigated.

For a more detailed analysis on provider enrollment across the physician specialist services category in the State of West Virginia, refer to **Table 4.15 Enrolled Physician Specialist Services by Provider Type** below.

**Table 4.15 Enrolled Physician Specialist Services by Provider Type**

<b>Physician Specialist Services: Number of Enrolled Providers by Provider Type</b>				
<b>Provider Type</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
OPTICIAN	45	46	32	-28.89%
CRNA	949	977	903	-4.85%
PHYSICIAN	5,277	5,335	5,053	-4.24%
DENTAL	616	610	608	-1.30%
OPTOMETRIST	217	213	218	0.46%
PODIATRIST	100	99	101	1.00%
INDEPENDENT LAB	203	212	207	1.97%
CHIROPRACTOR	150	147	157	4.67%
AUDIOLOGIST	62	68	67	8.06%
NURSE PRACTITIONER	16	26	39	143.75%
GROUP PROVIDER	11	40	77	600.00%
INDEPENDENT RADIOLOGY	0	0	2	N/A*
<b>Grand Total</b>	<b>7,646.00</b>	<b>7,773.00</b>	<b>7,464.00</b>	<b>-2.38%</b>
<b>Total Average</b>	<b>637.17</b>	<b>647.75</b>	<b>622.00</b>	<b>-2.38%</b>

*\*The percent in change from the years 2013 – 2015 could not be calculated due to the absence of providers in 2013.*

#### 4.4.2 Beneficiary Perceptions of ATC

As depicted in **Table 4.16 Medicaid Members per Physician Specialty Services Provider** below, the number of enrolled members per enrolled physician specialty services provider increased markedly from 2013 – 2015. As previously seen in the increase of MAGI adult-eligible members, much of the increase in member participation in Medicaid services may be attributed to the ACA Medicaid Expansion, while additional contributing factors may include, but not be limited to, West Virginia’s provider revalidation effort.

**Table 4.16 Medicaid Members per Physician Specialty Services Provider, 2013 – 2015**

<b>Medicaid Members per Physician Specialty Services Provider, 2013 – 2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
MCDOWELL	1,294.2	1,596.0	1,240.5	-4.1%
SUMMERS	1,231.5	1,985.0	1,388.7	12.8%
CALHOUN	788.5	652.8	917.3	16.3%
CLAY	1,112.0	1,894.5	1,334.7	20.0%

<b>Medicaid Members per Physician Specialty Services Provider, 2013 – 2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
HANCOCK	109.2	146.5	138.9	27.2%
PRESTON	345.3	627.6	444.3	28.7%
GRANT	109.9	268.7	144.3	31.3%
WYOMING	677.4	790.8	914.8	35.0%
MINERAL	271.5	379.6	390.5	43.8%
BOONE	534.8	852.9	788.8	47.5%
HARDY	289.3	461.6	439.7	52.0%
RALEIGH	78.2	121.6	124.9	59.6%
MONROE	294.7	546.5	471.4	60.0%
FAYETTE	187.0	293.3	302.9	61.9%
TUCKER	209.0	399.8	338.4	61.9%
WEBSTER	1,187.5	1,844.5	1,925.5	62.1%
TAYLOR	283.5	439.7	470.9	66.1%
CABELL	49.8	76.0	83.1	66.8%
MASON	184.2	255.1	308.1	67.3%
PUTNAM	169.0	293.6	290.5	71.9%
MORGAN	387.0	766.0	670.7	73.3%
GREENBRIER	83.1	134.3	144.9	74.4%
WOOD	69.2	112.7	121.5	75.6%
RANDOLPH	88.3	149.9	155.1	75.6%
BRAXTON	434.3	727.7	789.0	81.7%
BERKELEY	114.5	222.7	209.2	82.7%
MERCER	95.2	152.2	175.7	84.5%
GILMER	1,001.0	1,729.0	1,879.0	87.7%
LEWIS	114.4	182.7	216.2	88.9%
KANAWHA	39.0	68.2	73.8	89.4%
MONONGALIA	15.9	28.6	30.1	90.0%
JACKSON	171.5	305.2	331.2	93.1%
OHIO	27.0	50.4	52.4	94.2%
HARRISON	54.3	91.3	105.4	94.2%

<b>Medicaid Members per Physician Specialty Services Provider, 2013 – 2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
MINGO	369.3	605.9	724.8	96.3%
ROANE	292.6	448.0	578.8	97.8%
LOGAN	175.0	285.3	350.7	100.4%
JEFFERSON	152.9	260.6	310.1	102.8%
WETZEL	142.2	250.1	293.3	106.2%
POCAHONTAS	240.4	582.0	497.4	106.9%
MARION	91.5	162.7	189.9	107.6%
LINCOLN	1,004.8	1,146.3	2,115.5	110.5%
PENDLETON	152.3	453.3	324.3	112.9%
BROOKE	89.4	152.0	195.5	118.6%
NICHOLAS	174.6	317.1	382.6	119.1%
UPSHUR	139.2	286.1	317.0	127.6%
BARBOUR	431.3	901.2	982.2	127.7%
RITCHIE	395.0	507.4	902.0	128.4%
MARSHALL	114.7	237.0	275.9	140.5%
TYLER	212.2	498.8	541.5	155.2%
HAMPSHIRE	261.8	623.3	668.6	155.4%
WAYNE	488.5	901.5	1,259.0	157.7%
PLEASANTS	226.3	372.8	849.5	275.5%
DODDRIDGE	494.0	860.0	1,975.0	299.8%
<b>Grand Total</b>	<b>86.5</b>	<b>142.9</b>	<b>152.9</b>	<b>76.7%</b>

Findings indicate members per physician specialty services provider increased by as much as 299% at the county level (Doddridge County). Other counties experienced increases in the ratio of over 100%. This is a dual function of a decrease in the number of enrolled physician specialty services providers in many of those counties and an increase in the Medicaid-eligible population. Such increases of members per provider could result in fewer providers taking new Medicaid patients and could result in members having to travel considerable distances to obtain care.

The availability of enrolled providers in close proximity to members may impact members' perceptions of the accessibility of providers. Through regular monthly, quarterly, and yearly MMIS reporting and the provider and member surveys to be enacted upon CMS approval of the Access Monitoring Plan, BMS will continue to monitor the availability of physician specialty services to Medicaid enrollees.

For more information on the State’s ongoing access monitoring methodology, please refer to **Section 5.1 Ongoing Monitoring of ATC**, and for more information on the State’s provider and member surveys, please refer to **Appendix C: Access Monitoring Survey – Members** and **Appendix D: Access Monitoring Survey – Providers**.

#### 4.4.3 Beneficiary Utilization of Services

As measured by claims per member, **Table 4.17 Physicians Specialty Service Claims per Member (Top 10 Counties)** depicts the demand for physician specialist services in counties in West Virginia as a claim utilization per member ratio across the top 10 utilizing West Virginia counties.

**Table 4.17 Physicians Specialty Service Claims per Member (Top 10 Counties)**

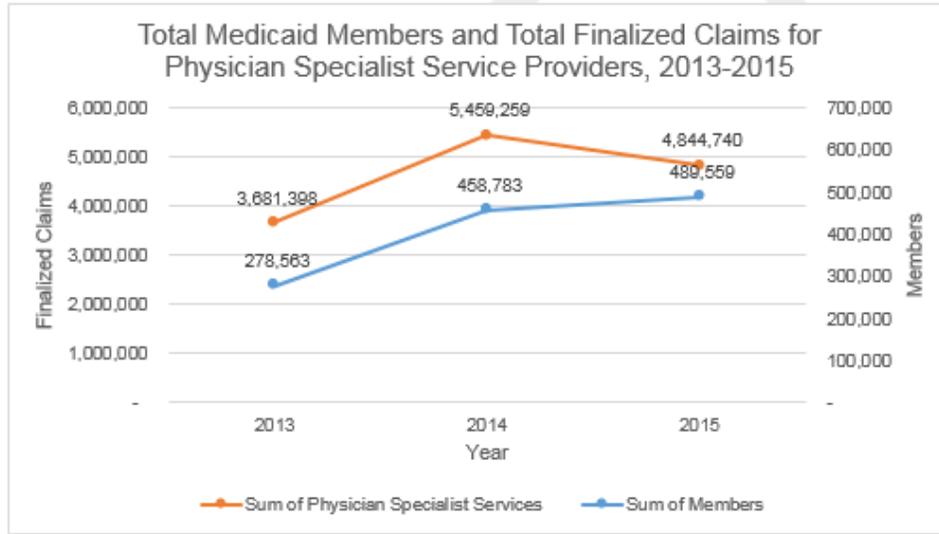
Physician Specialty Services Claims per Member (Top 10 Counties)				
County	2013	2014	2015	% Change
PLEASANTS	18.8	16.6	12.8	-31.91%
RALEIGH	18.2	16.0	13.4	-26.37%
FAYETTE	15.2	13.4	11.2	-26.32%
WYOMING	17.7	15.0	13.3	-24.86%
RITCHIE	16.7	15.4	13.0	-22.16%
WIRT	15.4	15.4	12.0	-22.08%
MCDOWELL	14.9	13.7	11.7	-21.48%
WOOD	19.7	19.5	16.1	-18.27%
HANCOCK	14.0	14.0	11.7	-16.43%
BROOKE	14.8	15.2	12.5	-15.54%
<b>Average of Top 10 Counties</b>	<b>16.54</b>	<b>15.42</b>	<b>12.77</b>	<b>-22.79%</b>
<b>Average of All Counties</b>	<b>12.7</b>	<b>11.4</b>	<b>9.4</b>	<b>-25.98%</b>

Findings indicate the counties shown in **Table 4.17 Physicians Specialty Service Claims per Member (Top 10 Counties)** experienced a higher than average utilization rate of physician specialty services when compared to that of the average across all counties in the State. Based on the relatively high rate of utilization in these counties, moving forward, BMS will closely monitor the availability of physician specialty services in these counties.

Additionally, **Figure 4.9 Total Physician Specialist Members and Total Number of Finalized Claims** reflects the total member and finalized claim counts for physician specialist service providers during the 2013 – 2015 calendar years. Overall findings indicate utilization across members was highest during the 2014 calendar year, with approximately five million physician specialist claims submitted in a program that serves more than 450,000 Medicaid members.

Please refer to **Figure 4.9** for more information.

**Figure 4.9 Total Physician Specialist Members and Total Number of Finalized Claims**



## 4.5 Behavioral Health Services

The West Virginia Medicaid program offers a comprehensive scope of medically necessary behavioral health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal regulations. Priority to these services has been given to children in the foster care system.

As of July 1, 2015, West Virginia Medicaid behavioral health services were transitioned from the State's FFS program to the State's WVMHT program. Individuals who are eligible for behavioral health services will continue to receive care initially via the State's FFS program; however, once they have selected their preferred MCO, their FFS enrollment will be terminated and their enrollment transitioned to the preferred MCO. For this reason, behavioral health services remained a part of the State's access monitoring analysis.

### 4.5.1 Provider Enrollment

**Table 4.10** describes the overall number of enrolled behavioral health services providers across the State of West Virginia throughout the calendar years 2013 – 2015. As represented in the below table, provider enrollment in the behavioral health services program decreased during the 2013 – 2015 calendar years by approximately 1.1% or approximately six providers.

**Table 4.108 Number of Enrolled Providers within the Behavioral Health Services Program**

Behavioral Health Services: Number of Enrolled Providers by County				
County/Commonwealth	2013	2014	2015	% Change
BOONE	No Providers	No Providers	No Providers	N/A*
CALHOUN	No Providers	No Providers	No Providers	N/A*
DODDRIDGE	No Providers	No Providers	No Providers	N/A*

<b>Behavioral Health Services: Number of Enrolled Providers by County</b>				
<b>County/Commonwealth</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
KENTUCKY (THE STATE)	1	No Providers	No Providers	N/A*
MONROE	No Providers	No Providers	No Providers	N/A*
PENDLETON	No Providers	No Providers	No Providers	N/A*
PLEASANTS	No Providers	No Providers	No Providers	N/A*
WEBSTER	1	No Providers	No Providers	N/A*
TYLER	2	2	No Providers	N/A*
MORGAN	No Providers	No Providers	1	N/A*
POCAHONTAS	No Providers	No Providers	1	N/A*
SUMMERS	No Providers	No Providers	1	N/A*
MASON	No Providers	1	1	N/A*
WIRT	No Providers	2	2	N/A*
FAYETTE	4	2	1	-75.00%
BARBOUR	3	2	1	-66.67%
TAYLOR	2	2	1	-50.00%
TUCKER	2	2	1	-50.00%
PRESTON	4	4	2	-50.00%
PENNSYLVANIA (THE STATE)	16	14	10	-37.50%
GREENBRIER	10	9	7	-30.00%
MARSHALL	4	2	3	-25.00%
JACKSON	4	3	3	-25.00%
WETZEL	4	5	3	-25.00%
HAMPSHIRE	8	7	6	-25.00%
NICHOLAS	12	9	9	-25.00%
RANDOLPH	12	10	10	-16.67%
LEWIS	7	7	6	-14.29%
WYOMING	7	7	6	-14.29%
WAYNE	10	10	9	-10.00%
OHIO (THE STATE)	10	12	9	-10.00%
BRAXTON	1	1	1	0.00%
GILMER	1	1	1	0.00%

<b>Behavioral Health Services: Number of Enrolled Providers by County</b>				
<b>County/Commonwealth</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
MCDOWELL	1	1	1	0.00%
RITCHIE	1	1	1	0.00%
MARYLAND (THE STATE)	2	2	2	0.00%
ROANE	2	2	2	0.00%
BROOKE	4	4	4	0.00%
GRANT	4	5	4	0.00%
LINCOLN	5	5	5	0.00%
UPSHUR	5	6	5	0.00%
HANCOCK	7	8	7	0.00%
JEFFERSON	8	7	8	0.00%
MINERAL	12	13	12	0.00%
MERCER	18	19	18	0.00%
KANAWHA	71	75	71	0.00%
OHIO	31	30	32	3.23%
HARRISON	30	30	31	3.33%
WOOD	28	34	29	3.57%
RALEIGH	25	25	26	4.00%
MONONGALIA	43	42	47	9.30%
CABELL	46	44	51	10.87%
PUTNAM	7	5	8	14.29%
LOGAN	7	7	8	14.29%
MINGO	4	4	5	25.00%
CLAY	3	4	4	33.33%
HARDY	3	5	4	33.33%
VIRGINIA (THE STATE)	10	9	14	40.00%
BERKELEY	20	28	28	40.00%
MARION	14	16	20	42.86%
<b>Grand Total</b>	<b>536.00</b>	<b>545.00</b>	<b>542.00</b>	<b>1.12%</b>
<b>Total Average</b>	<b>8.93</b>	<b>9.08</b>	<b>9.03</b>	<b>1.12%</b>

*\*Cannot calculate increase due to no providers in either 2013, 2015, or both.*

The State identified a slight increase (1.12%) across provider types for Behavioral Health and Social Services. However, the State experienced a much more pronounced increase in some areas, most notably social workers, whose enrollment increased by 233% from 2013 – 2015. This was offset somewhat by a decrease in the number of psychologists statewide enrolled to provide services to Medicaid beneficiaries. Enrolled psychologists decreased by 5.8%, or 19, from 2013 – 2015.

Please refer to **Table 4.18 Enrolled Behavioral Health and Social Services Providers by Provider** for more information on the number of enrolled providers by provider type across the behavioral health and social services program.

**Table 4.18 Enrolled Behavioral Health and Social Services Providers by Provider Type**

Behavioral Health Services: Number of Enrolled Providers by Provider Type				
Provider Type	2013	2014	2015	% Change
NURSE PRACTITIONER	0	0	1	N/A*
HABILITATION	0	1	2	N/A*
NON-PHYSICIAN PRACTITIONER	0	0	4	N/A*
THERAPIST	19	16	14	-26.32%
MENTAL HOSPITAL <21	24	23	20	-16.67%
PSYCHOLOGIST	328	325	309	-5.79%
MENTAL HEALTH REHABILITATION	76	78	77	1.32%
MENTAL HEALTH CLINIC	29	31	33	13.79%
RESPITE AND HABILITATION	54	56	62	14.81%
SOCIAL WORKER	6	15	20	233.33%
<b>Grand Total</b>	<b>536.00</b>	<b>545.00</b>	<b>542.00</b>	<b>1.12%</b>
<b>Total Average</b>	<b>48.73</b>	<b>49.55</b>	<b>49.27</b>	<b>1.12%</b>

*\*The percent in change from the years 2013 – 2015 could not be calculated due to the absence of providers in 2013.*

#### 4.5.2 Beneficiary Perceptions of ATC

Given the small number of enrolled behavioral health and social services providers, any change in the number of enrolled providers in a given geographical area has a marked effect on the area’s ratio of enrolled members to providers.

Similar to prior sections, this count represents the total number of eligible Medicaid members per enrolled providers in a given West Virginian county across the behavioral health and social services program.

For more information on eligible members per enrolled provider in West Virginia’s behavioral health and social services program, please refer to **Table 4.19**.

**Table 4.19 Medicaid Members per Behavioral Health and Social Services Provider, 2013 – 2015**

<b>Medicaid Members per Behavioral Health and Social Services Provider, 2013 – 2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
BOONE	No Providers	No Providers	No Providers	N/A*
CALHOUN	No Providers	No Providers	No Providers	N/A*
DODDRIDGE	No Providers	No Providers	No Providers	N/A*
MONROE	No Providers	No Providers	No Providers	N/A*
PENDLETON	No Providers	No Providers	No Providers	N/A*
PLEASANTS	No Providers	No Providers	No Providers	N/A*
WEBSTER	2,375.0	No Providers	No Providers	-100.0%
TYLER	530.5	997.5	No Providers	-100.0%
WIRT	No Providers	861.5	921.5	N/A**
POCAHONTAS	No Providers	No Providers	2,487.0	N/A**
MORGAN	No Providers	No Providers	4,024.0	N/A**
SUMMERS	No Providers	No Providers	4,166.0	N/A**
MASON	No Providers	6,887.0	7,395.0	N/A**
MARION	548.7	803.2	702.6	28.0%
MINGO	1,754.0	2,726.5	2,319.2	32.2%
CLAY	741.3	947.3	1,001.0	35.0%
BERKELEY	644.8	803.3	874.2	35.6%
MCDOWELL	6,471.0	9,576.0	9,924.0	53.4%
CABELL	404.1	684.1	644.0	59.4%
LOGAN	1,100.3	1,915.6	1,797.5	63.4%
PUTNAM	772.4	1,878.8	1,271.0	64.5%
LINCOLN	1,004.8	1,604.8	1,692.4	68.4%
RITCHIE	1,580.0	2,537.0	2,706.0	71.3%
WAYNE	977.0	1,442.4	1,678.7	71.8%
MERCER	714.0	1,121.2	1,259.0	76.3%
ROANE	1,463.0	2,464.0	2,604.5	78.0%
HARRISON	302.3	514.5	540.8	78.9%
MINERAL	271.5	438.0	488.1	79.8%
BROOKE	648.3	1,101.8	1,172.8	80.9%

<b>Medicaid Members per Behavioral Health and Social Services Provider, 2013 – 2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
OHIO	176.8	332.7	321.2	81.6%
BRAXTON	2,606.0	4,366.0	4,734.0	81.7%
MONONGALIA	161.9	316.7	303.7	87.7%
GILMER	1,001.0	1,729.0	1,879.0	87.7%
RALEIGH	513.2	905.0	974.2	89.8%
HANCOCK	530.6	824.3	1,032.0	94.5%
HARDY	2,025.0	1,846.5	3,957.0	95.4%
GRANT	384.5	591.2	757.5	97.0%
UPSHUR	696.2	1,049.2	1,394.6	100.3%
WYOMING	677.4	1,129.7	1,372.2	102.6%
WOOD	484.3	814.1	992.0	104.8%
GREENBRIER	716.9	1,225.9	1,469.9	105.0%
KANAWHA	380.8	647.2	801.5	110.5%
LEWIS	392.3	678.7	864.7	120.4%
JEFFERSON	554.4	1,303.1	1,240.5	123.8%
RANDOLPH	390.0	794.4	947.8	143.0%
WETZEL	640.0	900.4	1,564.0	144.4%
JACKSON	1,029.3	2,339.7	2,539.3	146.7%
NICHOLAS	392.9	916.1	977.7	148.8%
MARSHALL	974.8	3,437.0	2,482.7	154.7%
HAMPSHIRE	392.6	801.4	1,002.8	155.4%
TAYLOR	1,134.0	1,978.5	4,238.0	273.7%
PRESTON	1,036.0	1,882.8	3,999.0	286.0%
TUCKER	418.0	799.5	1,692.0	304.8%
BARBOUR	862.7	2,253.0	4,911.0	469.3%
FAYETTE	2,244.5	14,372.0	15,144.0	574.7%
<b>Grand Total</b>	<b>576.6</b>	<b>972.3</b>	<b>1,051.1</b>	<b>82.3%</b>
*No providers in county.				
**Percentage increase from zero cannot be calculated.				

As seen above, several counties have no behavioral health and social services providers. The lack of providers in given counties may help to explain the low rates of utilization of behavioral health and social services providers in counties with no such providers; however, it also may inform Medicaid members' perceptions on the availability of said providers within the State. Although behavioral health services may be provided by other provider types, the State will need to closely monitor this service category in support of sufficient ATC.

The State has previously recognized a shortage of behavioral health and social services providers Statewide and in specific counties, and the State believes they have assisted in the mitigation of this deficiency by migrating behavioral health services from the FFS delivery model to WVMHT. With the transition of these services from FFS to WVMHT occurring on July 1, 2015, the State continues to monitor overall per member per provider counts in an effort to mitigate this known ATC deficiency.

Through the use of monthly, quarterly, and yearly MMIS reporting and ongoing surveys to the member and provider communities to be enacted upon CMS approval of the Access Monitoring Plan, BMS will continue to monitor beneficiaries' access to behavioral health services.

For more information on the State's ongoing access monitoring methodology, please refer to **5.1 Ongoing Monitoring of ATC**, and for more information on the State's provider and member surveys, please refer to **Appendix C: Access Monitoring Survey – Members** and **Appendix D: Access Monitoring Survey - Providers**.

#### 4.5.3 Beneficiary Utilization of Services

As measured by claims per member, the table below depicts the demand for behavioral health and social services in counties in West Virginia as a claim utilization per member ratio across the top 10 utilizing West Virginia counties.

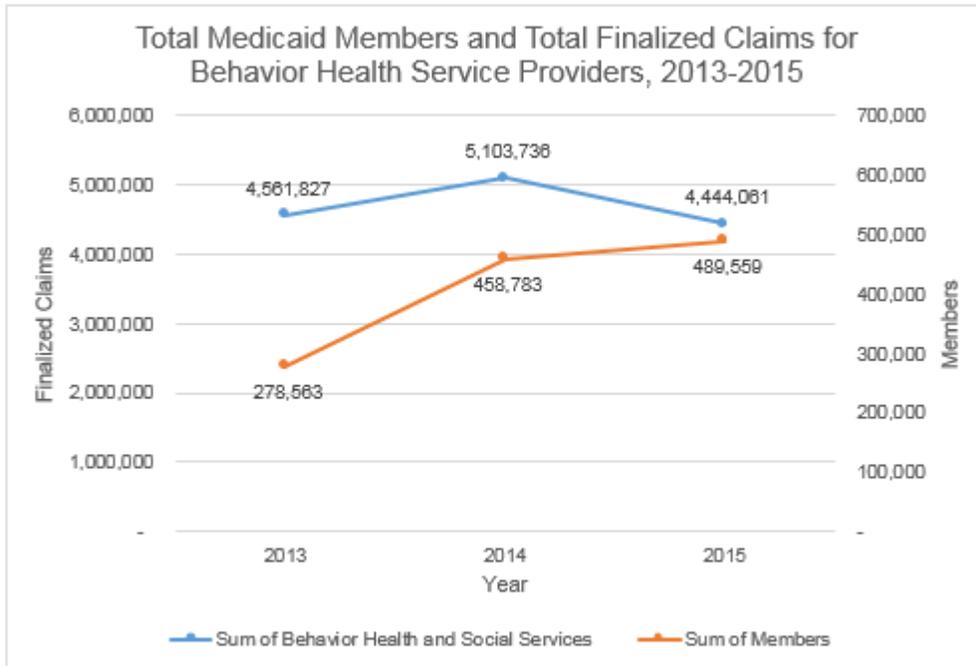
**Table 4.20 Behavioral Health Services Claims per Member (Top 10 Counties)**

Behavioral Health Services Claims per Member (Top 10 Counties)				
County	2013	2014	2015	% Change
GRANT	35.04	18.96	14.67	-58.13%
MARSHALL	65.02	35.89	28.92	-55.52%
OHIO	73.95	42.30	35.19	-52.41%
PLEASANTS	20.35	14.13	10.31	-49.34%
WETZEL	53.87	33.15	28.48	-47.13%
BERKELEY	21.33	13.04	11.45	-46.32%
CABELL	28.82	20.74	15.56	-46.01%
WOOD	16.83	12.50	10.41	-38.15%
RANDOLPH	15.00	11.46	11.09	-26.07%
HARRISON	13.43	11.52	11.85	-11.76%

<b>Average of Top 10 Counties</b>	<b>34.36</b>	<b>21.37</b>	<b>17.79</b>	<b>-48.23%</b>
<b>Average of All Counties</b>	<b>15.1</b>	<b>9.7</b>	<b>8.0</b>	<b>-47.02%</b>

Findings indicate that Medicaid beneficiaries across the top 10 utilizing counties utilized behavioral health and social services at rates of nearly three to four times State averages. However, as can be seen in **Figure 4.11 Behavioral Health Providers – Total Medicaid Members and Finalized Claims**, there was a drop in finalized claims for behavioral health service providers from 2014 – 2015, with the total number of finalized claims being fewer in 2015 than in 2013 prior to the expansion.

**Figure 4.11 Behavioral Health Providers – Total Medicaid Members and Finalized Claims**



These findings fall in line with that of the member per provider counts within the behavioral health and social services category; counties with more behavioral health and social services providers saw higher utilization of those services across the 2013 – 2015 calendar year span. This further indicates the need for additional providers to support behavioral health and social services program.

Although the findings indicate claim utilization rates nearly three to four times that of the State average, findings indicate the top utilizing county, Ohio County, had a ratio of 306.3:1 behavioral health providers to members in 2015, well below the State’s average of 958.1:1. The accessibility of providers in Ohio County may be a contributing factor to the member’s ability to locate and utilize behavioral health and social services in that locality.

#### **4.6 Home Health Services**

A West Virginia Medicaid enrolled home health agency provides medically necessary and appropriate services, such as skilled nursing (SN), home health aide (HHA), physical therapy

(PT), speech therapy (ST), occupational therapy (OT), certain medically necessary supplies, other therapeutic services, and nutritional services. Those eligible for home healthcare are individuals that must need a skilled level of care on an intermittent basis, physical therapy, speech-language pathology services, or have a continued need for occupational therapy. There are no age restrictions for members who are eligible to receive home health services.

#### 4.6.1 Provider Enrollment

Overall enrollment in the State of West Virginia’s home health services service category has remained relatively stable throughout the 2013 – 2015 calendar years.

For the detailed number of enrolled providers across West Virginia counties for calendar years 2013 – 2015, please refer to **Table 4.21**.

**Table 4.21 Number of Enrolled Home Health Services Providers**

Home Health Services: Number of Enrolled Providers by County				
County/Commonwealth	2013	2014	2015	% Change
CALHOUN	No Providers	No Providers	No Providers	N/A*
CLAY	No Providers	No Providers	No Providers	N/A*
GILMER	No Providers	No Providers	No Providers	N/A*
HAMPSHIRE	No Providers	No Providers	No Providers	N/A*
HARDY	No Providers	No Providers	No Providers	N/A*
LINCOLN	No Providers	No Providers	No Providers	N/A*
MARYLAND (COMMONWEALTH)	No Providers	No Providers	No Providers	N/A*
MCDOWELL	No Providers	No Providers	No Providers	N/A*
MINGO	No Providers	No Providers	No Providers	N/A*
MONROE	No Providers	No Providers	No Providers	N/A*
MORGAN	No Providers	No Providers	No Providers	N/A*
PLEASANTS	No Providers	No Providers	No Providers	N/A*
POCAHONTAS	No Providers	No Providers	No Providers	N/A*
RITCHIE	No Providers	No Providers	No Providers	N/A*
SUMMERS	No Providers	No Providers	No Providers	N/A*
TUCKER	No Providers	No Providers	No Providers	N/A*
TYLER	No Providers	No Providers	No Providers	N/A*
VIRGINIA (COMMONWEALTH)	No Providers	No Providers	No Providers	N/A*
WEBSTER	No Providers	No Providers	No Providers	N/A*

Home Health Services: Number of Enrolled Providers by County				
County/Commonwealth	2013	2014	2015	% Change
WIRT	No Providers	No Providers	No Providers	N/A*
WYOMING	No Providers	No Providers	No Providers	N/A*
PUTNAM	No Providers	No Providers	1	N/A*
OHIO (COMMONWEALTH)	3	2	2	-33.33%
BARBOUR	1	1	1	0.00%
BERKELEY	1	1	1	0.00%
BOONE	1	1	1	0.00%
BRAXTON	1	1	1	0.00%
BROOKE	1	1	1	0.00%
CABELL	5	5	5	0.00%
DODDRIDGE	1	1	1	0.00%
FAYETTE	1	1	1	0.00%
GRANT	1	1	1	0.00%
GREENBRIER	2	2	2	0.00%
HARRISON	2	2	2	0.00%
JACKSON	2	2	2	0.00%
JEFFERSON	1	1	1	0.00%
KANAWHA	4	4	4	0.00%
KENTUCKY (COMMONWEALTH)	1	1	1	0.00%
LEWIS	1	1	1	0.00%
LOGAN	2	2	2	0.00%
MARION	2	3	2	0.00%
MARSHALL	2	2	2	0.00%
MASON	1	1	1	0.00%
MERCER	3	3	3	0.00%
MINERAL	1	1	1	0.00%
MONONGALIA	4	4	4	0.00%
NICHOLAS	1	1	1	0.00%
OHIO	3	3	3	0.00%
PENDLETON	1	1	1	0.00%

Home Health Services: Number of Enrolled Providers by County				
County/Commonwealth	2013	2014	2015	% Change
PENNSYLVANIA (COMMONWEALTH)	1	1	1	0.00%
PRESTON	1	1	1	0.00%
RALEIGH	3	3	3	0.00%
RANDOLPH	1	1	1	0.00%
ROANE	1	1	1	0.00%
TAYLOR	1	1	1	0.00%
UPSHUR	1	1	1	0.00%
WAYNE	1	1	1	0.00%
WETZEL	1	1	1	0.00%
WOOD	3	3	3	0.00%
HANCOCK	1	1	2	100.00%
<b>Grand Total</b>	<b>64.00</b>	<b>64.00</b>	<b>65.00</b>	<b>1.56%</b>
<b>Total Average</b>	<b>1.07</b>	<b>1.07</b>	<b>1.08</b>	<b>1.56%</b>
*No providers in county.				
**Percentage increase from zero cannot be calculated.				

Similarly to above, **Table 4.22** below highlights the provider type specific to the home health service category.

**Table 4.22 Number of Enrolled Home Health Services Providers by Provider Type**

Home Health Services: Number of Enrolled Providers by Provider Type				
Provider Type	2013	2014	2015	% Change
HOME HEALTH AGENCY	65	65	66	1.54%
<b>Total Average</b>	<b>65</b>	<b>65</b>	<b>66</b>	<b>1.54%</b>

#### 4.6.2 Beneficiary Perceptions of ATC

Given the small number of enrolled home health service providers, any change in the number of enrolled providers in a given geographical area has a marked effect on the area's ratio of enrolled members to providers.

Similar to prior sections, the counts in **Table 4.23** represents the total number of eligible Medicaid members per enrolled home health provider in a given West Virginian county across the home health program.

For more information on eligible members per enrolled provider in West Virginia's home health program, please refer to **Table 4.23**.

**Table 4.23 Medicaid Members per Home Health Services Provider, 2013 – 2015**

Medicaid Members per Home Health Services Provider, 2013 – 2015				
County	2013	2014	2015	% Change
CALHOUN	No Providers	No Providers	No Providers	N/A*
CLAY	No Providers	No Providers	No Providers	N/A*
GILMER	No Providers	No Providers	No Providers	N/A*
HAMPSHIRE	No Providers	No Providers	No Providers	N/A*
HARDY	No Providers	No Providers	No Providers	N/A*
LINCOLN	No Providers	No Providers	No Providers	N/A*
MCDOWELL	No Providers	No Providers	No Providers	N/A*
MINGO	No Providers	No Providers	No Providers	N/A*
MONROE	No Providers	No Providers	No Providers	N/A*
MORGAN	No Providers	No Providers	No Providers	N/A*
PLEASANTS	No Providers	No Providers	No Providers	N/A*
POCAHONTAS	No Providers	No Providers	No Providers	N/A*
RITCHIE	No Providers	No Providers	No Providers	N/A*
SUMMERS	No Providers	No Providers	No Providers	N/A*
TUCKER	No Providers	No Providers	No Providers	N/A*
TYLER	No Providers	No Providers	No Providers	N/A*
WEBSTER	No Providers	No Providers	No Providers	N/A*
WIRT	No Providers	No Providers	No Providers	N/A*
WYOMING	No Providers	No Providers	No Providers	N/A*
PUTNAM	No Providers	No Providers	10,168.0	N/A**
HANCOCK	3,714.0	6,594.0	3,612.0	-2.7%
WAYNE	9,770.0	14,424.0	15,108.0	54.6%
MASON	4,421.0	6,887.0	7,395.0	67.3%
FAYETTE	8,978.0	14,372.0	15,144.0	68.7%
WOOD	4,520.3	7,327.3	7,935.7	75.6%
MERCER	4,284.0	7,100.7	7,554.0	76.3%
CABELL	3,717.8	6,020.4	6,568.6	76.7%
ROANE	2,926.0	4,928.0	5,209.0	78.0%

<b>Medicaid Members per Home Health Services Provider, 2013 – 2015</b>				
<b>County</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>% Change</b>
GREENBRIER	2,867.5	4,903.5	5,144.5	79.4%
MINERAL	3,258.0	5,694.0	5,857.0	79.8%
BOONE	4,813.0	7,676.0	8,677.0	80.3%
BROOKE	2,593.0	4,407.0	4,691.0	80.9%
BRAXTON	2,606.0	4,366.0	4,734.0	81.7%
RANDOLPH	4,680.0	7,944.0	8,530.0	82.3%
MARION	3,841.0	4,283.7	7,025.5	82.9%
WETZEL	2,560.0	4,502.0	4,692.0	83.3%
HARRISON	4,534.0	7,717.5	8,383.0	84.9%
JACKSON	2,058.5	3,509.5	3,809.0	85.0%
NICHOLAS	4,715.0	8,245.0	8,799.0	86.6%
LOGAN	3,851.0	6,704.5	7,190.0	86.7%
TAYLOR	2,268.0	3,957.0	4,238.0	86.9%
OHIO	1,827.0	3,327.3	3,425.7	87.5%
LEWIS	2,746.0	4,751.0	5,188.0	88.9%
BARBOUR	2,588.0	4,506.0	4,911.0	89.8%
RALEIGH	4,277.0	7,541.7	8,118.3	89.8%
MARSHALL	1,949.5	3,437.0	3,724.0	91.0%
PRESTON	4,144.0	7,531.0	7,998.0	93.0%
KANAWHA	6,759.8	11,973.5	13,225.5	95.7%
GRANT	1,538.0	2,956.0	3,030.0	97.0%
BERKELEY	12,252.0	22,492.0	24,478.0	99.8%
DODDRIDGE	988.0	1,720.0	1,975.0	99.9%
UPSHUR	3,481.0	6,295.0	6,973.0	100.3%
MONONGALIA	1,740.0	3,325.0	3,569.0	105.1%
PENDLETON	914.0	1,813.0	1,946.0	112.9%
JEFFERSON	4,435.0	9,122.0	9,924.0	123.8%
<b>Grand Total</b>	<b>4,808.1</b>	<b>8,021.8</b>	<b>8,477.5</b>	<b>76.3%</b>
*No providers in county.				
**Percentage increase from zero cannot be calculated.				

The table above depicts, in some cases, extreme ratios of members to providers. As an example, Berkeley County shows a nearly 100% increase in its ratio of members to providers, though this was due to the disenrollment of one provider between 2013 – 2014. The small numbers of providers in this ATC Service Category lead in some cases to very high ratios of members to providers.

As seen in the prior sections, the State experienced a net of one additional home health agency enrolled as a Medicaid provider between the years of 2013 – 2014, bringing the total number of such agencies to 65. As demonstrated in **Table 4.23**, far more members are eligible for said home health services than there are available providers. Statewide, the ratio of members to home health service providers increased by 76% from 2013 – 2015.

This finding is considered a deficiency in the State Medicaid program and may be attributed to the program's current status and/or maturity level. Regardless, the State plans to examine the home health services program to further explore potential avenues for increasing provider enrollment and/or the availability of home health services to the citizens of West Virginia.

#### 4.6.3 Beneficiary Utilization of Services

As measured by claims per member, **Table 4.24** below depicts the demand for home health services in counties in West Virginia as a claim utilization per member ratio across the top ten utilized West Virginia counties.

For more information on beneficiary utilization of services across the home health services program, please refer to **Table 4.24**.

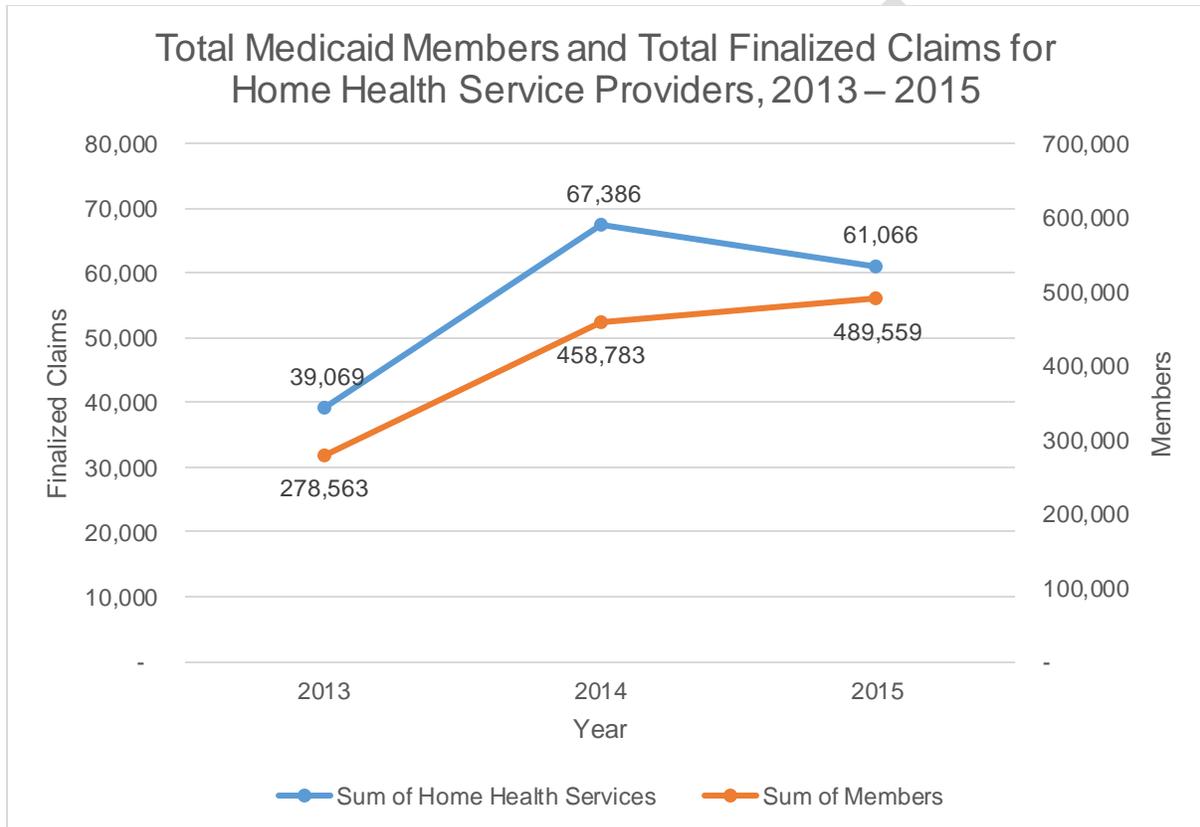
**Table 4.24 Home Health Services Claims per Member (Top 10 Counties)**

Home Health Services Claims per Member (Top 10 Counties)				
County	2013	2014	2015	% Change
CABELL	0.27	0.26	0.25	-7.41%
PLEASANTS	0.20	0.23	0.19	-5.00%
WOOD	0.17	0.25	0.17	0.00%
BERKELEY	0.20	0.31	0.20	0.00%
WETZEL	0.32	0.40	0.34	6.25%
OHIO	0.48	0.66	0.59	22.92%
KANAWHA	0.13	0.17	0.17	30.77%
MARSHALL	0.40	0.46	0.54	35.00%
BROOKE	0.08	0.07	0.17	112.50%
GRANT	0.12	0.28	0.27	125.00%
<b>Average of Top 10 Counties</b>	<b>0.24</b>	<b>0.31</b>	<b>0.29</b>	<b>20.83%</b>
<b>Average of All Counties</b>	<b>0.14</b>	<b>0.16</b>	<b>0.13</b>	<b>-7.14%</b>

Findings indicate that home health services are the least-utilized service in terms of claims per member out of the five ATC service categories, with the statewide average being just 0.13 claims per member in 2015.

Please refer to **Figure 4.12 Total Medicaid Members and Total Finalized Claims for Home Health Service Providers, 2013 – 2015** for more information.

**Figure 4.12 Total Medicaid Members and Total Finalized Claims for Home Health Service Providers, 2013 – 2015**



## 5. Approach to Monitoring ATC

The purpose of this section is to describe West Virginia's approach to monitoring ATC. This section will utilize the data compiled from various Medicaid enterprise stakeholders to highlight West Virginia specific ATC baselines, thresholds, assumptions, and trends. This information will be used to monitor West Virginia ATC to ensure the following data elements are assessed on a reoccurring basis:

1. The extent to which beneficiary needs are fully met
2. The availability of care through enrolled providers
3. Changes in beneficiary service utilization
4. Comparisons between Medicaid rates and rates paid by other public and private payers

This section will also describe the State's approach to continuous ATC monitoring, as well as details on the State's plan to conduct ATC assessments in support of State Plan Amendments (SPA).

The Final Rule requires that states establish procedures in their access monitoring review plan to monitor ATC on an ongoing basis after the implementation of service rate reductions or payment restricting. The Final Rule also requires States to implement processes to demonstrate ATC is sufficient as of the effective dates identified within State Plan Amendments. As a part of these monitoring efforts, the associated procedures must be in place for a period of at least three years after the effective date of the State Plan Amendment.

The Final Rule also requires states to establish ongoing mechanisms for beneficiary and provider feedback on ATC. Potential mechanisms may include but are not limited to hotlines, surveys, ombudsman, review of grievance and appeals data, or other equivalent mechanism to support collection of ongoing provider and beneficiary feedback. After establishing and collecting input from both the provider and member communities, states must also maintain a record of the data and how input was responded to.

The following section details the State's ATC monitoring procedures, as well as plans to monitor ATC before, during, and after State Plan Amendments (SPA).

### 5.1 Ongoing Monitoring of ATC

Monitoring of ATC across the following service categories will be supported by data provided to BMS by West Virginia's MMIS fiscal agent and data warehouse vendor in the form of monthly, quarterly, and yearly reports.

- Primary Care Services
- Physician Specialist Services
- Behavioral Health Services
- Home Health Services

In addition to data collection via reports, providers and members will be able to send ATC feedback, comments, and or concerns to the State via an online survey, email address, and/or mailing.

In accordance with the Final Rule, this plan and the associated data elements will be updated and submitted to CMS for their review and approval every three years. Additionally, the following reports and associated analyses will be compiled on a reoccurring basis and submitted to BMS senior leadership for their review and consideration in drafting of related SPAs.

**Table 5.1 Ongoing ATC Measures** identifies ATC measures and frequency at which related data elements will be requested from the MMIS fiscal agent and data warehouse vendor to support the State of West Virginia’s overall access monitoring efforts.

**Table 5.1 Ongoing ATC Measures**

Measure	Frequency of Data Collection	Vehicle (Report, Survey, etc.)
Provider Enrollment	Monthly	Report
Provider Types and Specialties	Monthly	Report
Beneficiary Eligibility, Gender, and Age Characteristics	Quarterly	Report
Beneficiary Requests for Assistance	Monthly	Report and Survey
Beneficiary Perceptions of ATC	Monthly	Report and Survey
Beneficiary Utilization of Services	Quarterly	Report
Medicaid, Medicare, and Other Payer Rates	Yearly	Report and Data Collection
Mailings, Email, Surveys, and Phone	Ongoing	Refer to <b>Table 5.2</b>

**Provider Enrollment and Provider Type and Specialties:** The State’s MMIS fiscal agent will generate and distribute a provider enrollment report on a monthly basis that highlights the total number of providers within the West Virginia Medicaid network that comprise the ATC service categories.

**Beneficiary Eligibility, Gender, and Age Characteristics:** On a quarterly basis, the State’s MMIS fiscal agent will provide BMS a report that highlights Medicaid member eligibility, age, and gender characteristics similar to those depicted in **4.2.2 Beneficiary Eligibility, Gender, and Age Characteristics**.

**Beneficiary Requests for Assistance:** On a monthly basis, the State will utilize two reports for the purposes of examining beneficiary requests for assistance. The first will be provided by the State’s MMIS fiscal agent and will contain incoming call metrics from the MMIS call center where Medicaid members made requests for information on West Virginia Medicaid in-network providers. The second report will contain the findings that stem from the Access Monitoring survey for members depicted in **Appendix C: Access Monitoring Survey – Members**.

**Beneficiary Perceptions of ATC:** The State plans to utilize enrolled Medicaid provider and member data to create a report that speaks to the ratio of enrolled providers and members across the ATC service categories similar to the findings depicted in **4.2.4 Beneficiary Perceptions of ATC**. Additionally, the State plans to utilize on an ongoing basis, the surveys depicted in **Appendix C: Access Monitoring Survey – Members** and **Appendix D: Access Monitoring Survey – Providers**.

The State has also solicited assistance from their data warehouse vendor in obtaining reports that provide geographical representations of provider service locations and member’s physical addresses. This visual aid will be supplied on a quarterly basis.

**Beneficiary Utilization of Services:** On a monthly basis, the State’s MMIS fiscal agent will work with the State to supply a report that highlights member claim counts across the, broken down by town, city, and/or county, across each of the ATC service categories.

**Medicaid, Medicare, and Other Payer Rates:** On a yearly basis, the State will request that the MMIS fiscal agent provide rates across the ATC service categories for the top 10 billed CPT and HCPCS codes. These rates will then be compared to the rates of commercial payers to provide insight into the impact State Medicaid rates and corresponding reimbursements have on Medicaid provider’s and member’s ATC.

To supplement the above access monitoring efforts, West Virginia also maintains grievance and appeals data for members and providers which may be used to inform the State’s overall access monitoring.

In addition to the above approach to Access Monitoring, providers and members are invited to send ATC concerns and/or feedback to BMS via postal mail, email, survey, and/or telephone as described below:

**Table 5.2 Contact Information for Public Comment Period**

Feedback Method	Contact Information
<b>Mail:</b>	WVDHHR Bureau for Medical Services ATTN: Access to Care 350 Capitol Street Charleston, WV 25301
<b>Email:</b>	<a href="mailto:MedicaidATC@wv.gov">MedicaidATC@wv.gov</a>
<b>Provider and Member ATC Survey:</b>	Once the Access Monitoring Plan has been approved by CMS, the provider and member surveys depicted in Appendices C and D will be made available at <a href="https://www.dhhr.wv.gov/bms">https://www.dhhr.wv.gov/bms</a> .
<b>Phone:</b>	304-558-1700

## 6. ATC Deficiencies

This section will provide details specific to any access to care deficiencies, as well as information specific to the monitoring, identification, and mitigation of any identified deficiencies. This section will also highlight the State's Corrective Action Plan (CAP) development, review, and approval process.

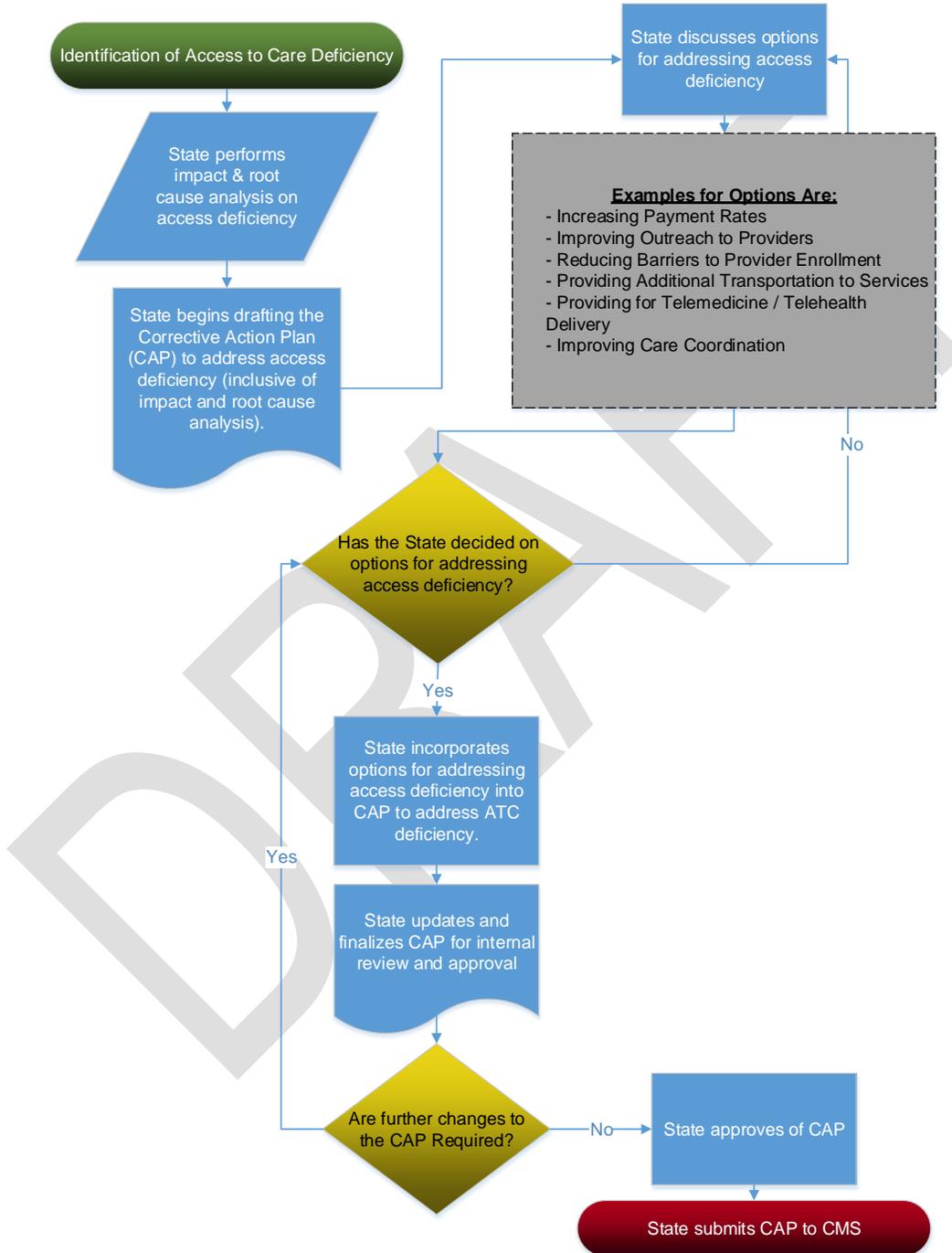
As a part of the West Virginia's Medicaid FFS access monitoring efforts, the Final Rule requires the State to submit a CAP to CMS within 90 days of discovery and identification of an access deficiency. The submitted action plan must contain specific steps and timelines to address issues, and aim to remediate the access deficiency within 12 months. Remediation efforts may include but are not limited to increasing payment rates; improving outreach to providers, reducing barriers to provider enrollment; providing additional transportation to services; or improving care coordination. The rule also requires that access improvements are measurable and sustainable.

The State of West Virginia also understands that CMS may take a compliance action to assist in remedy of an access deficiency.

**Figure 6.1 Access Corrective Action Plan Development, Review, and Approval Process** on the following page provides a visual representation of the State of West Virginia's ATC deficiency remediation methodology.

**Figure 6.1 Access Corrective Action Plan Development, Review, and Approval Process**

Project:	West Virginia Bureau for Medical Services Access to Care Project	
Business Process:	Access to Care Deficiencies: Corrective Action Plan (CAP) Development, Review, & Approval Process	



As ATC evidence for the aforementioned Medicaid services continues to be gathered and reviewed, BMS will be the entity responsible for the identification of access deficiencies. Once the deficiency has been identified, BMS will work with a variety of stakeholders to perform an impact and root cause analysis of said access deficiency.

After the State has performed an impact and root cause analysis, the State will begin drafting the CAP.

Although BMS will be the entity developing and approving the CAP prior to it being submitted to CMS, the following stakeholders will also be encouraged to participate in the development, review, and approval of the State of West Virginia's Access Deficiency Corrective Action Plan(s).

- Department of Health and Human Resources
- Medical Services Fund Advisory Council
- State Project Management Organization

The CAP, once approved by CMS, will be stored on the State of West Virginia's BMS website, and the associated process to address the access deficiency will be implemented.

For more information on the CAP, please refer to **Appendix F: Corrective Action Plan Template** to view West Virginia's CAP Template.

## 7. Acronyms/Abbreviations

This section will highlight acronyms and abbreviations used throughout this plan. It will also include detailed descriptions and definitions for each of the identified acronyms and abbreviations.

The following table represents acronyms and abbreviations used throughout the Access Monitoring Plan.

**Table 7.1 Acronyms and Abbreviations**

Acronym/Abbreviation	Definition
ACA	Affordable Care Act
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
ATC	Access to Care
ATC Service Categories	<p>The four service categories of focus for ATC monitoring. The categories are:</p> <ul style="list-style-type: none"> <li>• Primary Care Services</li> <li>• Physician Specialists</li> <li>• Behavioral Health Services</li> <li>• Home Health Services</li> </ul> <p>Although the Final Rule identifies prenatal and postnatal obstetric services (including labor and delivery) as an ATC service category, West Virginia did not include this service category in their analysis as it is supported by the State's managed care healthcare delivery system WVMHT</p>
BAT	Behavioral Analyst Technician
BCaBA	Board Certified assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BMS	Bureau for Medical Services
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CORC	Comprehensive Outpatient Rehabilitation Center
FFS	Fee-For-Service

Acronym/Abbreviation	Definition
Final Rule	42 CFR Part 447 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services; Final Rule
FQHC	Federally Qualified Health Center
HHA	Home Health Aid
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IADL	Instrumental Activities of Daily Living
I/DD	Intellectual/ Developmental Disability
IDTF	Independent Diagnostic Testing Facility
LPC	Licensed Professional Counselor
LTAC	Long Term Acute Care
MCO	Managed Care Organizations
MMIS	Medicaid Management Information System
OT	Occupational Therapy
PAAS	Physician Assured Access System
Plan	West Virginia Access Monitoring Plan
PT	Physical Therapy
RBT	Registered Behavior Technician
RFQ	Request for Quotations
RVU	Relative Value Units
SN	Skilled Nursing
SPA	State Plan Amendments
ST	Speech Therapy
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
WVDHHR	West Virginia Department of Health and Human Resources
WVMHT	West Virginia Mountain Health Trust

## 8. Conclusion

This section will summarize the State of West Virginia's Access Monitoring Review Plan and will focus on highlighting any identified deficiencies and their associated corrective action plans. This section will also describe next steps as they relate to the access monitoring review plan, as well as its implementation.

In accordance with the ACA, during 2013 – 2015 calendar years, the West Virginia Medicaid community expanded greatly. The State saw an 82% increase in member enrollment during the 2013 – 2015 calendar years. Given that Medicaid expansion under the ACA went into effect on January 1, 2014, a large increase in member enrollment was to be expected in the expansion population. Indeed, the MAGI adult population, a large part of the expansion, added over 200,000 members between these years; however, children's Medicaid also expanded greatly over the three-year time span, from 10,040 to 74,836, an increase of nearly 650%.

For more information on enrollment, please see **Section 3.2.2 Beneficiary Eligibility, Gender, and Age Characteristics**.

While Medicaid membership increased at a high rate, due mostly to expansion, the Medicaid provider population supplying the ATC Service Categories studied in this plan increased by approximately 503 providers, or 3.75%. Aside from the increase in enrollment, physician specialists providers had a net decline from 7,093 to 6,911 enrolled providers statewide in the three-year span. Despite the decline in this ATC specific service category, primary care service providers saw a significant net increase of enrollment between the 2013 – 2015 calendar years, adding 690 providers to Medicaid enrollment for a 12.1% increase. The State believes this increase is due in large part to the ACA's support of a rate increase for primary care service providers. In total, from 2013 – 2015 Medicaid provider enrollment for the ATC Service Categories increased by 503 from 13,407 to 13,910, or a 3.75% increase. Further information on provider enrollment can be found in **Section 3.2.1 Provider Enrollment**.

As shown by the Kaiser Family Foundation's analysis of HPSAs in West Virginia and nationwide,<sup>1</sup> a general lack of primary care providers is not as significant a problem in West Virginia as it is in many other states. This suggests that the barriers to ATC are concentrated in more specialized services, an idea that is supported by the low provider enrollment numbers in behavioral health services and home health services, as well as lower utilization rates among counties without such services.

For FFS Medicaid, West Virginia consistently reimburses providers at a higher per-service rate than the United States; however, its reimbursement rates are generally lower than those offered for Medicare patients, as shown in **Section 3.2.6 Medicaid, Medicare, and Other Payer Rates**. Across all services for Medicaid patients, providers receive a reimbursement that is on average 79% less than what they would receive for Medicare patients, which may lead providers to prioritize Medicare patients and those with private health insurance. This must be

<sup>1</sup> <http://kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/>

closely monitored for more specialized services, notably behavioral health services, to ensure that the limited number of providers who render such services are both numerous enough and properly incentivized to provide services to the Medicaid population.

Similarly, home health providers (**Section 3.6**) are notably absent in 20 West Virginia counties; however, by definition, Medicaid beneficiaries are not required to travel to home health providers to receive Medicaid services. The services supplied by this provider type and received by these beneficiaries will be closely monitored as a function of West Virginia's ongoing access monitoring.

Behavioral health and social services are unavailable in many areas in the State, with nine counties as of the close of 2015 not having any enrolled behavioral health and social services providers, and several others having extremely limited availability. Given the high utilization of such services (4.4 million claims in 2015), the relative unavailability of behavioral health and social services providers may present a significant obstacle to ATC in West Virginia. However, the State recognizes that the lack of a given provider or providers in a given county does not constitute an ATC deficiency, as said services may be provided by providers within a nearby county and/or commonwealth. As discussed in **Section 3.1 Methodology**, the State is also planning to analyze the geographical distribution of members and providers further to gain a clearer understanding of Medicaid beneficiaries' access to behavioral health and social services.

Although overall findings suggest provider enrollment across nearly 75% of the State is increasing, further analysis suggests additional healthcare coverage may be needed in the behavioral health and social services and home health services, as represented throughout **Section 3.0 Data Findings and Analysis**. While new members appear to not be utilizing Medicaid as much as others, the behavioral health services and home health services coverage needs have increased. This presents an ATC risk that in part was addressed by the migration of the behavioral health services population over to the WVMHT program; however, close monitoring across both service categories will continue to be required as the State implements the Plan.

As mandated by the Final Rule, this Plan will be updated on a triennially basis. The Plan will continue to be executed in the intervening time period. As discussed in **Section 4.1 Ongoing Monitoring of ATC**, the State will gather information on a monthly, quarterly, and annual basis to maintain an understanding of ATC in the State and any issues that may arise or persist. As part of this Plan, the State has developed ATC feedback mechanisms for the Medicaid community available on an ongoing basis online, and via phone, mailing, and/or email. Using the information similar to that presented herein the Plan, and supplemented with information from surveys, mailings, phone calls, and emails from the Medicaid stakeholder community, the State will conduct ongoing analyses of ATC in the State and, if determined to be necessary, create and implement a CAP within 90 days as mandated by the Final Rule. The implementation of the CAP will then be monitored and success determined by an ongoing analysis of ATC.

## Appendix A: ATC Provider Type and Specialty List

The following table identifies provider types, specialties, and the related Medicaid service categories that were of focus for the Access Monitoring Review Plan. It's important to note that as feedback on the Plan is compiled, the below list is subject to change.

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
05	Mental Hospital less than 21	B0	Psych under 21	Behavior Health and Social Services
05	Mental Hospital less than 21	B2	Psych Residential Treatment Facility	Behavior Health and Social Services
35	I/DD Waiver	H6	I/DD Waiver	Behavior Health and Social Services
52	Mental Health Clinic	C6	Behavioral Health Clinic	Behavior Health and Social Services
92	Psychologist	W8	Psychology	Behavior Health and Social Services
92	Psychologist	W9	School Psychologist	Behavior Health and Social Services
93	Mental Health Rehabilitation	W1	Child Group Residential	Behavior Health and Social Services
93	Mental Health Rehabilitation	W0	Rehabilitation	Behavior Health and Social Services
94	TBI Provider	Q7	TBI Personal Attendant	Behavior Health and Social Services
94	TBI Provider	Q8	TBI Case Management Agency	Behavior Health and Social Services
92	Psychologist	N7	Neuropsychologist	Behavior Health and Social Services
76	Behavior Health and Social Services	CP	Licensed Professional Counselor (LPC)	Behavior Health and Social Services
76	Behavior Health and Social Services	CH	Board Certified Behavior Analyst (BCBA)	Behavior Health and Social Services
76	Behavior Health and Social Services	CI	Board Certified assistant Behavior Analyst (BCaBA)	Behavior Health and Social Services
76	Behavior Health and Social Services	CT	Behavioral Analyst Technician (BAT)	Behavior Health and Social Services

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
76	Behavior Health and Social Services	CR	Registered Behavior Technician (RBT)	Behavior Health and Social Services
76	Behavior Health and Social Services	CU	Nationally Certified Addiction (SUD) Counselor	Behavior Health and Social Services
58	Home Health Agency	F7	Home Health Agency	Home Health Services
02	Group Provider	E6	Vision Group	Physician Specialist Services
02	Group Provider	E7	Dental Group	Physician Specialist Services
02	Group Provider	EF	Podiatry Group	Physician Specialist Services
02	Group Provider	EB	Chiropractic Group	Physician Specialist Services
02	Group Provider	ED	Physical Therapy Group	Physician Specialist Services
02	Group Provider	EG	Psychological Group	Physician Specialist Services
18	Physician	C9	Hospitalist	Physician Specialist Services
18	Physician	A7	Bariatric Procedures	Physician Specialist Services
18	Physician	G2	Hearing Aids	Physician Specialist Services
18	Physician	GE	Gerontology	Physician Specialist Services
18	Physician	K1	Laboratory	Physician Specialist Services
18	Physician	K6	Critical Care	Physician Specialist Services
18	Physician	K9	Genetics	Physician Specialist Services
18	Physician	L0	Anesthesiology	Physician Specialist Services
18	Physician	L2	Infectious Disease	Physician Specialist Services

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
18	Physician	L3	Neonatology	Physician Specialist Services
18	Physician	L4	Neurophysiology	Physician Specialist Services
18	Physician	L5	Colorectal	Physician Specialist Services
18	Physician	L6	Proctology	Physician Specialist Services
18	Physician	L8	Sports Medicine	Physician Specialist Services
18	Physician	L9	Oncology	Physician Specialist Services
18	Physician	M0	Dermatology	Physician Specialist Services
18	Physician	M1	Allergy	Physician Specialist Services
18	Physician	M2	Pediatric Cardiology	Physician Specialist Services
18	Physician	M5	Hematology	Physician Specialist Services
18	Physician	M6	Cardiology	Physician Specialist Services
18	Physician	M7	Endocrinology	Physician Specialist Services
18	Physician	M8	Nephrology	Physician Specialist Services
18	Physician	M9	Gastroenterology	Physician Specialist Services
18	Physician	N0	Neurosurgery	Physician Specialist Services
18	Physician	N1	Neurology	Physician Specialist Services
18	Physician	N2	Radiation Oncology	Physician Specialist Services
18	Physician	N3	Rheumatology	Physician Specialist Services

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
18	Physician	N4	Vascular Surgery	Physician Specialist Services
18	Physician	N6	Immunology	Physician Specialist Services
18	Physician	P0	Ophthalmology	Physician Specialist Services
18	Physician	P5	Orthopedics	Physician Specialist Services
18	Physician	Q0	Otolaryngology	Physician Specialist Services
18	Physician	Q1	Otorhinolaryngology	Physician Specialist Services
18	Physician	Q2	Rhinology	Physician Specialist Services
18	Physician	Q3	Otology	Physician Specialist Services
18	Physician	Q5	Pathology	Physician Specialist Services
18	Physician	Q6	Nuclear Medicine	Physician Specialist Services
18	Physician	R1	Physiatry	Physician Specialist Services
18	Physician	R2	Plastic Surgery	Physician Specialist Services
18	Physician	R3	Geriatrics	Physician Specialist Services
18	Physician	R4	Pulmonary	Physician Specialist Services
18	Physician	R5	Psychiatry	Physician Specialist Services
18	Physician	R6	Radiology	Physician Specialist Services
18	Physician	R7	General Surgery	Physician Specialist Services
18	Physician	R8	Thoracic Surgery	Physician Specialist Services

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
18	Physician	R9	Cardio Surgery	Physician Specialist Services
18	Physician	S0	Urology	Physician Specialist Services
21	Podiatrist	P2	Podiatric Surgery	Physician Specialist Services
21	Podiatrist	P6	Podiatry	Physician Specialist Services
22	Chiropractor	S1	Chiropractic	Physician Specialist Services
31	Optometrist	H9	Optometrist	Physician Specialist Services
32	Optician	V1	Vision Center	Physician Specialist Services
34	Audiologist	W5	Audiology	Physician Specialist Services
40	Dental	S5	General Dentist	Physician Specialist Services
40	Dental	S7	Orthodontist	Physician Specialist Services
40	Dental	T0	Oral and Maxillofacial Surgeon	Physician Specialist Services
40	Dental	T1	Periodontist	Physician Specialist Services
40	Dental	T2	Pediatric Dentist	Physician Specialist Services
40	Dental	T3	Endodontist	Physician Specialist Services
40	Dental	L1	Prosthodontist	Physician Specialist Services
40	Dental	T4	Other Dentist	Physician Specialist Services

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
40	Dental	D0 NOTE: Never exists on own	Dental Anesthesia	Physician Specialist Services
18	Physician	IR	Interventional Radiology	Physician Specialist Services
18	Physician	IC	Interventional Cardiology	Physician Specialist Services
18	Physician	CE	Cardiac Electrophysiology	Physician Specialist Services
18	Physician	A6	Pain Management	Physician Specialist Services
18	Physician	PR	Resident	Physician Specialist Services
02	Group Provider	EA	Audiology Group	Physician Specialist Services
02	Group Provider	EJ	Anesthesia Group	Physician Specialist Services
02	Group Provider	EK	Optometry Group	Physician Specialist Services
02	Group Provider	E1	Physician Group	Primary Care Services
02	Group Provider	E3	Nurse Practitioner	Primary Care Services
09	FQHC	F2	FQHC	Primary Care Services
18	Physician	K5	General Practice	Primary Care Services
18	Physician	K7	Family Practice	Primary Care Services
18	Physician	M3	Emergency Medicine	Primary Care Services
18	Physician	M4	Internal Medicine	Primary Care Services
18	Physician	R0	Pediatrics	Primary Care Services
53	Rural Health Clinic	S3	Rural Health Clinic	Primary Care Services
71	Nurse Practitioner	AD	Adult Nurse Practitioner	Primary Care Services
71	Nurse Practitioner	R0	Pediatrics	Primary Care Services
71	Nurse Practitioner	K7	Family Practice	Primary Care Services

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
995	Nonphysician Practitioner	H0	Physician Assistant	Primary Care Services
02	Group Provider	E1	Physician Group	Primary Care Services
02	Group Provider	A8	Multi-Specialty Group	Primary Care Services
01	Hospital	A0	Acute Care	N/A
01	Hospital	R6	Radiology (Will not exist on its own)	N/A
01	Hospital	K1	Laboratory	N/A
01	Hospital	J6	Outpatient Rehab (CORF)	N/A
01	Hospital	A5	Critical Access Hospital	N/A
01	Hospital	J5	Outpatient Hospital/Partial Hospitalization	N/A
01	Hospital	LA	LTAC	N/A
01	Hospital	A3	Rehabilitation	N/A
02	Group Provider	E2	CAH Group	N/A
02	Group Provider	E4	Education School Group	N/A
02	Group Provider	EH	IDTF Group	N/A
02	Group Provider	E9	PAAS Provider Group	N/A
04	Renal Center	F4	Dialysis	N/A
06	Hospice	D5	Hospice	N/A
06	Hospice	B9	Hospice Nursing Home Provider	N/A
10	Long Term Care	B6	ICF/IID	N/A
10	Long Term Care	B5	Nursing Facility	N/A
10	Long Term Care	B4	Skilled Nursing Facility	N/A
26	CRNA	L0	Anesthesiology	N/A
28	Homemaker Agency	H7	Homemaker	N/A
29	Personal Care Provider	C5	Personal Care Agency	N/A
47	Case Management Agency	H4	Case Management Agency	N/A

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
48	School Based Services	F0	Education Special Ed Project	N/A
49	Right From the Start	RF	Right From the Start	N/A
62	Durable Medical Equipment	X0	Medicare Crossover Only	N/A
62	Durable Medical Equipment	G0	Orthotist	N/A
62	Durable Medical Equipment	G5	Orthotic Fitter	N/A
62	Durable Medical Equipment	G4	Augmentative Communication Device	N/A
62	Durable Medical Equipment	PE	Pedorthics	N/A
62	Durable Medical Equipment	RE	Respiratory/Oxygen	N/A
62	Durable Medical Equipment	G3	Supplies	N/A
62	Durable Medical Equipment	G1	DME	N/A
63	Durable Medical Equipment- Prostheses	G8	Ocularist	N/A
63	Durable Medical Equipment- Prostheses	G9	Prosthetic	N/A
63	Durable Medical Equipment- Prostheses	G7	Mastectomy Fitter	N/A
67	Independent Lab	K1	Laboratory	N/A
68	Independent Radiology	R6	Radiology	N/A
69	Ambulatory Surgical Center	S2	Ambulatory Surgical Center	N/A
71	Nurse Practitioner	GE	Gerontology	N/A
71	Nurse Practitioner	R5	Psychiatric	N/A
73	Physical Therapist	WA	Physical Therapy	N/A
74	Speech Therapist	V5	Speech Therapy	N/A
74	Speech Therapist	V6	School Speech Therapy	N/A

Provider Type	BMS Long Description	Specialty Number	Specialty Description	Applicable Service Category
75	Occupational Therapist	W3	Occupational Therapy	N/A
80	Transportation	U1	Air Ambulance	N/A
80	Transportation	U0	Ambulance	N/A
80	Transportation	U2	Non-Emergency	n/a
97	Private Duty Nurse Agency	W6	Agency	N/A
97	Private Duty Nurse	W7	School Based	N/A
98	Certified Diabetes Educators	C8	Diabetes Management	N/A
995	Nonphysician Practitioner	H2	Clinical Social Worker	N/A
51	Health Departments	H8	Health Department	N/A
54	Pain Management Clinic	A6	Pain Management	N/A
02	Group Provider	EL	Speech Therapy Group	N/A
02	Group Provider	EM	Occupational Therapy Group	N/A
995	Nonphysician Practitioner	LC	Licensed Certified Social Worker (LCSW)	N/A
995	Nonphysician Practitioner	LS	Licensed Independent Clinical Social Worker (LICSW)	N/A
02	Group Provider	E5	Nurse Midwife Group	N/A
08	Birthing Center	B3	Birthing Center	N/A
18	Physician	N5	OBGYN	N/A
71	Nurse Practitioner	W4	Nurse Midwife	N/A
71	Nurse Practitioner	WO	Nurse Practitioner Women's Health	N/A

## Appendix B: Access Monitoring Plan Coming Soon Notification

To provide advanced notice of the Access Monitoring Plan's distribution for public comment, the below notification was published on the State of West Virginia BMS website on June 6, 2016, and on the West Virginia MMIS Portal on June 13, 2016.

### ***The Draft Access Monitoring Review Plan is coming soon!***

*In an effort to monitor Medicaid members' access to services, and in accordance with [42 CFR 447.203](#), the West Virginia Bureau for Medical Services (BMS) will be developing an Access Monitoring Plan. The Plan will outline the processes used to monitor Medicaid members' ATC in West Virginia.*

*The Plan will measure ATC by analyzing administrative claims utilization data, rate comparison data analysis, and health quality survey data.*

### ***The following service categories subject to this analysis as described in 42 CFR 447.203 are listed below:***

- *Primary Care Services*
- *Physician Specialist Services*
- *Behavioral Health Services*
- *Prenatal and Postnatal Obstetric Services (including labor and delivery)*
- *Home Health Services*

*The draft Plan will be posted on the West Virginia Bureau for Medical Services website for a 30 day public comment period prior to submission to the Centers for Medicare and Medicaid Services (CMS).*

*State Medicaid stakeholders, inclusive of providers and members, are encouraged to provide comments and feedback. Public comments may be incorporated throughout the final version of the Plan and may influence ATC recommendations going forward.*

*In the final Plan, BMS will make a determination regarding the sufficiency of ATC for Medicaid members in West Virginia and, if necessary, provide recommendations for improvement of any identified access deficiencies. These recommendations will be informed and supported by public input, health quality survey data, payment rate comparison, and administrative claim utilization analysis.*

## **Appendix C: Access Monitoring Survey – Members**

The following survey will be made available on the BMS website (<http://www.dhhr.wv.gov/bms>) for the purposes of collecting Medicaid member feedback on potential ATC deficiencies.

DRAFT



8. If you have needed healthcare services in the past 12 months, how often have healthcare providers been able to address your issues and/or concerns? **(Checkbox)**

- Does Not Apply
- Never
- Sometimes
- Usually
- Always

9. In the past 12 months, when you had to visit a provider, have you been able to find: **(Check all that apply)**

- Adequate transportation
- Childcare coverage
- Work coverage
- Flexible appointments
- Your preferred provider
- Other (please specify):  
\_\_\_\_\_

10. In the past 12 months, have you faced any language difficulties/barriers when trying to get healthcare? **(Checkbox)**

- Yes
- No

11. What is the biggest obstacle(s) you have faced regarding access to healthcare? **(Write text)**

12. Please provide any additional comments or concerns: **(Write text)**

### Contact Information:

Providing the following information is optional.

_____	_____	
First Name	Last Name	
_____	_____	_____
Address	City	State
_____	_____	_____
Zip Code	Email	Phone

**Thank you for taking the time to complete our survey. Your input is greatly appreciated.**

## **Appendix D: Access Monitoring Survey – Providers**

The following survey will be made available on the BMS website (<http://www.dhhr.wv.gov/bms>) for the purposes of collecting Medicaid provider feedback on potential ATC deficiencies.

DRAFT

## ATC Monitoring Survey - Providers

Please take a few minutes to fill out this survey regarding access to Medicaid services. Your feedback is greatly appreciated, and thank you for your participation.

### Access Information

1. What is your enrolled provider type? (List All That Apply) \_\_\_\_\_
2. What is your enrolled provider specialty? (List All That Apply) \_\_\_\_\_

3. What county(ies) and/or States do you provide Medicaid services in? \_\_\_\_\_

4. Do you provide West Virginia Medicaid Home Health Services? **(Checkbox)**

Yes       No

If yes, please specify the corresponding Home Health Service(s):  
\_\_\_\_\_  
\_\_\_\_\_

5. In the past 12 months, how often have you had to refer patients to another healthcare provider due to overbooked schedule? **(Checkbox)**

Does Not Apply  
 Never  
 Sometimes  
 Usually  
 Always

6. In the past 12 months, how often you had patients contact another healthcare provider due to a misunderstanding of services provided at your location (that you know of)? **(Checkbox)**

Does Not Apply  
 Never  
 Sometimes  
 Usually  
 Always

7. In the past 12 months, when patients visited your location, have you heard concerns or complaints about: **(Check all that apply)**

Adequate transportation  
 Childcare coverage  
 Work coverage  
 Flexible appointments  
 Selecting a preferred provider  
 Other (please specify):  
\_\_\_\_\_

8. Does your location have staff/healthcare providers who can speak multiple languages? **(Checkbox)**

Yes       No

If yes, please specify the language(s) spoken:

\_\_\_\_\_

9. In the past 12 months, have patients visiting your location experienced any language difficulties/barriers? **(Checkbox)**

Yes       No

If yes, please specify:

\_\_\_\_\_

10. Are you currently accepting, or willing to accept new Medicaid patients?

- Does Not Apply
- Yes
- No
- Maybe

11. What do you feel is the biggest obstacle(s) your patients have faced regarding access to healthcare?

12. Please provide any additional comments or concerns in relation to ATC that your clients may have expressed: **(Write text)**

**Contact Information:**

Providing the following information is optional.

\_\_\_\_\_  
First Name                      Last Name                      NPI Number

\_\_\_\_\_  
Address                      City                      County

\_\_\_\_\_  
State                      Zip Code                      Email                      Phone

**Thank you for taking the time to complete our survey! Your input is greatly appreciated.**

## Appendix E: Access Monitoring Plan Survey

The following survey is available on the BMS website (<http://www.dhhr.wv.gov/bms>) for the purposes of collecting public feedback on the Access Monitoring Plan.

DRAFT

## ATC Monitoring Plan Survey

Please take a few minutes to fill out this survey regarding the ATC Monitoring Plan. Your feedback is greatly appreciated. Thank you for your participation.

### Plan Feedback

1. Please rate the extent to which you agree with the layout of the Plan.

- 1                       2                       3                       4                       5  
Disagree                      Neutral                      Agree

2. If you have specific comments on the layout of the Plan, please provide them here.

3. Please rate the extent to which you agree with the data measures used to measure ATC in the Plan as it relates to your provider type/specialty.

- 1                       2                       3                       4                       5                       N/A\*  
Disagree                      Neutral                      Agree

4. If you have specific comments on the data measures used to measure in the Plan, please provide them here.

5. Please rate the extent to which you agree with the analytic methods used to measure ATC in the Plan as it relates to your provider type/specialty.

- 1                       2                       3                       4                       5                       N/A\*  
Disagree                      Neutral                      Agree

6. If you have specific comments concerning the analytic methods used to measure ATC in the Plan, please provide them here:

## Additional Feedback

### Demographic Information

1. What is your affiliation?

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Provider | <input type="checkbox"/> Medicaid Member                          |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Group                                    |
| <input type="checkbox"/> Agency   | <input type="checkbox"/> Stakeholder/Other (please specify) _____ |

2. What is your primary service interest?

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Behavioral Health            | <input type="checkbox"/> Obstetrics   | <input type="checkbox"/> Specialty Care |
| <input type="checkbox"/> Home Health                  | <input type="checkbox"/> Primary Care | <input type="checkbox"/> Any/all listed |
| <input type="checkbox"/> Dentist                      | <input type="checkbox"/> Physician    |   |
| <input type="checkbox"/> Other (please specify) _____ |                                       |   |

Please list any additional comments or concerns.

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### Contact Information

Providing the following information is optional.

_____			
First Name	Last Name	NPI	
_____			
Address	City	County	
_____			
State	Zip Code	Email	Phone
_____	_____	_____	_____

**Thank you for taking the time to complete our survey. Your input is greatly appreciated.**

## Appendix F: Corrective Action Plan Template

The following pages highlight the corrective action template to be used upon identification of access deficiencies.

DRAFT



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***West Virginia Access to Care (ATC)  
Access Monitoring Plan  
Corrective Action Plan***

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Date of Publication: XX/XX/XXXX  
Document Version: Template

## 1.0 Introduction

The introduction section will speak to *42 CFR Part 447 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services; Final Rule* as well as the purpose of the Corrective Action Plan (CAP).

### 1.1 Description of Problem, Root Cause, and Impact

The section will provide information that speaks to the State's overall access monitoring efforts as well as the related access deficiency. This section will contain background information on the State's overall access monitoring efforts and related deficiency; inclusive of a description of the access to deficiency, how it was identified, the root cause, and the related impact.

## 2.0 Corrective Action Plan Implementation

This section will provide a high level approach to implementation of the access deficiency's corrective action plan. It will be inclusive of the CAP's objective and approach to remediation, and will include a section specific to the documentation of any related risk, issue, or item for escalation.

## **2.1 Objective**

This section will describe the CAP's objective and will provide a high level approach to implementation of the access deficiency's corrective action plan.

## **2.2 Approach**

This section will supply details on the State's overall approach to mitigation of the identified access deficiency, as well as a description of the responsible stakeholders. This section will also speak to how the access deficiency will be monitoring following the implementation of related mitigation tactics.

## **2.3 Risks, Issues, and Escalation**

This section will speak to potential risks, issues, and/or escalation items related to the implementation of the corrective action plan. These items will also be considered throughout the implementation of the related corrective action.

## **3.0 Summary of Corrective Action Plan**

This section will provide a summary of the CAP, related findings, and appropriate next steps. It will reiterate the parties responsible for implementation of corrective processes, and speak to how said processes will be monitored.