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MEDICAID MADE RIGHT

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# MEDICAID MADE RIGHT

## POLICY REFORM RECOMMENDATIONS FOR WEST VIRGINIA'S MEDICAID PROGRAM

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# MEDICAID MADE RIGHT

## EXECUTIVE OVERVIEW

Medicaid continues to serve as one of the most consequential and complex health programs in the United States—supporting more than 92 million Americans nationwide, including approximately 530,000 West Virginians.[1] As the state's largest public expenditure, Medicaid represents a substantial portion of West Virginia's general revenue budget. While the program has expanded access to care and improved outcomes for vulnerable populations, its long-term fiscal sustainability and administrative efficiency remain central concerns for policymakers across all levels of government.

At the federal level, momentum around Medicaid modernization continues to build. Congressional leaders and the Centers for Medicare & Medicaid Services (CMS) are exploring large-scale reform through initiatives such as the "One Big, Beautiful Bill"—a bipartisan policy concept aimed at enhancing transparency, confirming eligibility, and expanding the adoption of value-based care. At the same time, CMS continues to emphasize managed care as a primary strategy to drive accountability, contain costs, and improve member-centered outcomes nationwide.

In West Virginia, these national priorities intersect with familiar state challenges. The Medicaid program faces escalating costs driven by long-term services and supports (LTSS), persistent workforce shortages, and fragmented vendor systems that complicate oversight and increase administrative burden. While managed care has produced measurable improvements in access and quality, additional opportunities exist to reform pricing structures, strengthen vendor accountability, and align reimbursement with measurable performance outcomes.

Recognizing the need for targeted reform, the state's four Medicaid Managed Care Organizations (MCOs)—Aetna Better Health, Highmark Health Options, The Health Plan, and Wellpoint—joined together through the West Virginia Association of Health Plans (WVAHP) to launch the Medicaid Made Right (MMR) initiative in early 2025. This collaborative initiative represents a proactive, data-driven effort to identify, evaluate, and recommend practical policy and operational reforms designed to enhance efficiency, strengthen fiscal stewardship, and improve health outcomes across the Medicaid program.

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[1] West Virginia Department of Human Services (DoHS). *Medicaid and CHIP Enrollment Data, June 2024.* Charleston, WV: Bureau for Medical Services, 2024.

The creation of MMR coincided with renewed legislative and executive interest in reforming West Virginia's Medicaid program. Lawmakers, agency leaders, and health-system partners share a common objective: ensuring that every Medicaid dollar is used efficiently and that services are delivered through a streamlined, accountable, and sustainable system. Medicaid Made Right serves as the managed care community's coordinated response to that mission—providing the West Virginia Department of Human Services' (DoHS) Bureau for Medical Services (BMS) and policymakers with actionable, evidence-based strategies to guide reform.

Through structured committee discussions, targeted policy research, and stakeholder collaboration, the MMR initiative developed a guiding framework centered on three strategic priorities—Price, Process, and Policy. This framework underpins the recommendations that follow and reflects the combined expertise of West Virginia's managed care organizations in advancing practical, achievable Medicaid reform.

## WHAT IS MEDICAID MADE RIGHT

Medicaid Made Right is a collaborative policy modernization initiative established by West Virginia's four Medicaid Managed Care Organizations through the West Virginia Association of Health Plans. The initiative functions as both a policy framework and an implementation coalition, designed to improve the fiscal sustainability, operational efficiency, and care quality of the state's Medicaid program.

MMR was developed on the principle that the organizations most directly engaged in care delivery and system management are uniquely positioned to identify areas for improvement. By combining state-level data analytics, operational insights, and best practices from peer states, MMR provides policymakers and BMS with a comprehensive, evidence-based blueprint for reform.

At its core, the MMR framework is structured around three interdependent pillars. These priorities form the foundation for all Medicaid Made Right policy recommendations and guide the coalition's approach to system transformation.

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### 1. Price

Establish transparent and standardized reimbursement methodologies across all Medicaid services. The objective is to replace outdated or inconsistent pricing structures with a uniform model aligned to federal and regional benchmarks. Reasoned pricing methodologies promote equity among providers, reduces administrative waste, and enhances fiscal predictability for both the state and its partners.

### 2. Process

Modernize administrative processes within West Virginia Medicaid by streamlining vendor management, improving credentialing efficiency, reducing duplicative contracts, and strengthening data-sharing infrastructure. Process reforms are designed to eliminate redundancy, improve accountability, and promote operational efficiency across agencies, vendors, and MCOs.

### 3. Policy

Advance legislative and regulatory reforms that enable sustainable, outcomes-driven care delivery. Policy priorities include expanding managed care integration, supporting value-based reimbursement models, and improving coordination for high-cost populations, including those receiving long-term services and supports and dual-eligible members.

## MMR PROCESS AND STAKEHOLDER ENGAGEMENT

The MMR initiative was developed through a multi-phase process coordinated by the WVAHP in partnership with the state's four MCOs. The goal of this process was to identify policy and operational reforms that would improve the fiscal stability, administrative efficiency, and quality of the West Virginia Medicaid program.

### A. Committee Formation and Purpose

WVAHP convened the MMR Policy Committee, composed of leadership and representatives from each MCO and policy advisors who collaborated to guide the initiative's development. The Committee was tasked with evaluating West Virginia Medicaid's current administrative and financial landscape, assessing areas of inefficiency, and identifying practical reforms aligned with federal trends and best practices.

### B. Analytical Methodology

The Committee's work was grounded in three analytical pillars:

1. **Comparative Research** – Reviewing other states' Medicaid reform models, including Tennessee's *CHOICES* program for managed long-term care, Ohio's *MyCare* model for dual eligibles, and Kentucky's payment standardization reforms.

2. **Data Review** – Analyzing CMS data sets, actuarial models from *Milliman*, *MACPAC* reports, and West Virginia-specific expenditure and claims data.

3. **Stakeholder Input** – Gathering insights from MCOs and external experts via facilitated workshops and surveys.

Following the workshop, a post-meeting evaluation was distributed to all participants. Results reflected exceptional engagement: 100% of respondents found the meeting's objectives "very clear," and 99% rated it as "very valuable." Participants also shared insights and reference materials to guide the next phase, drawing on publicly available research from organizations such as the Kaiser Family Foundation (KFF), the Centers for Medicare & Medicaid Services, American Health Insurance Plans (AHIP), and Mathematica Policy Research.

### C. Key Findings

Through this process, the Committee identified systemic challenges within the state's Medicaid structure, including:

- Duplicative vendor contracting and administrative fragmentation;
- Outdated reimbursement methodologies that obscure fiscal transparency;
- Rising behavioral health expenditures without measurable quality gains; and
- Limited data standardization across benefit categories.

To address these issues, five consensus policy recommendations were developed, each designed to strengthen Medicaid's fiscal integrity, improve quality of care, and align West Virginia's program with leading national practices.

## POLICY RECOMMENDATIONS

The following five policy proposals emerged from the MMR Committee's deliberations. Each is supported by national evidence, cost modeling, and operational feasibility within West Virginia's Medicaid environment.

### POLICY PROPOSAL #1

### Transition Long-Term Services and Supports (LTSS) to Managed Care

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#### Background

Long-Term Services and Supports encompass a continuum of medical and non-medical care for individuals with chronic illnesses, disabilities, or functional limitations. In West Virginia, LTSS represent a major and growing share of Medicaid spending. National data show that individuals who are eligible due to age or disability — populations most likely to use LTSS — account for approximately half of all Medicaid expenditures. West Virginia's Medicaid program has a higher-than-average share of beneficiaries with complex health needs, further elevating the importance of strengthening LTSS efficiency and care coordination.[2] In addition to high costs, West Virginia continues to perform in the lowest national tier for LTSS, according to AARP's *2023 LTSS State Scorecard: Innovation and Opportunity*.[3] In fact, West Virginia ranks 51 out of 51 states including Washington, D.C. The program currently operates under a predominantly fee-for-service (FFS) model, which limits cost predictability, creates fragmented care coordination, and restricts opportunities for outcome-based management.

#### National Context

Many states have transitioned some or all LTSS populations into managed care models known as Managed Long-Term Services and Supports (MLTSS). According to MACPAC, 24 states currently operate MLTSS programs, a model designed to improve

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[2] Medicaid and CHIP Payment and Access Commission (MACPAC). *MACStats: Medicaid and CHIP Data Book.* December 2024. "Key Statistics from MACStats," p. 10. Washington, DC. Available at: https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf.

[3] Reinhard, S., Harrell, R., Blakeway Amero, C., et al. (2023). *Innovation and Opportunity: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.* Washington, D.C.: AARP Public Policy Institute. Available at: https://ltsschoices.aarp.org/scorecard-report/innovation-and-opportunity.

quality, reduce institutionalization, and enhance beneficiary satisfaction.[4] More states are looking to do the same.

States such as Tennessee and Virginia have reported measurable program improvements under MLTSS. In Tennessee, the CHOICES program has continued to rebalance LTSS toward home- and community-based services (HCBS) and reduce reliance on institutional care, as reflected in TennCare's annual and CMS evaluation reports.[5] In Virginia, CCC Plus evaluations document improvements in care coordination and quality measures across medical and LTSS benefits, though fiscal impacts are mixed across years.[6]

### West Virginia Application

A transition to MLTSS would allow West Virginia to:

- Integrate care for dual-eligible and high-need populations;
- Reinvest savings from reduced institutional care into community-based supports;
- Introduce quality-based payment incentives for providers; and
- Improve beneficiary outcomes through managed coordination and monitoring.

## POLICY PROPOSAL #2
## Establish a Statewide Telehealth Access Framework

### Background

The COVID-19 pandemic transformed how care is delivered across the United States, accelerating the adoption of telehealth as a vital tool for improving access, continuity, and affordability of healthcare services. Utilization of telehealth among Medicaid and CHIP beneficiaries increased more than twenty-fold between 2019 and 2020, according

[4] Medicaid and CHIP Payment and Access Commission (MACPAC). *Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution.* June 2022. Available at: https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/.
[5] TennCare. *Annual Report, State Fiscal Year 2024.* Nashville, TN: TennCare, May 2025.
[6] Virginia DMAS. *CCC Plus External Quality Review Technical Report.* Richmond, VA: DMAS, 2022.

to the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE).[7] Behavioral health and primary care accounted for the majority of these encounters, underscoring telehealth's value in reaching populations with chronic or high-acuity needs.

While many states have maintained expanded telehealth flexibilities, others—including West Virginia—have experienced uneven adoption due to variable broadband access, inconsistent reimbursement guidance, and differing managed-care protocols.[8] These barriers have disproportionately affected rural, low-income, and elderly populations, limiting equitable access to virtual care.

**National Context**

Several states, including Delaware, North Carolina, and Kansas, have implemented comprehensive Medicaid telehealth frameworks that focus on standardized coverage policies, streamlined licensure processes, and strategic broadband investment. Evaluations by the Health Resources and Services Administration (HRSA) and federal telehealth programs have shown that robust telehealth systems enhance access, support chronic-disease management, and improve behavioral-health engagement.[9]

**West Virginia Application**

To modernize its Medicaid delivery system, West Virginia could develop a Statewide Telehealth Access Framework—a unified strategy that establishes minimum standards for coverage, technology, and coordination across all Medicaid programs and managed care organizations. Key components would include:

- Guaranteed access to telehealth services for all Medicaid members, regardless of geographic location or provider type;
- Integration of behavioral and maternal health services into telehealth delivery networks, particularly in underserved rural regions;

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[7] U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE). *Trends in Medicaid and CHIP Telehealth, 2019–2021.* Washington, D.C., 2024. Available at: https://aspe.hhs.gov/sites/default/files/documents/1aba23cdcb4673c2f6c62ac8a01e6db8/Medicaid_Telehealth%20IB_FINAL_08072024.pdf.

[8] Centers for Medicare & Medicaid Services (CMS). *State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Telehealth.* Baltimore, MD: U.S. Department of Health and Human Services, 2023. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/state-medicaid-chip-telehealth-toolkit.pdf.

[9] Health Resources and Services Administration (HRSA). *National Telehealth Conference Summary Report. September 2023. Rockville, MD: Health Resources and Services Administration.*

- Interoperable telehealth coordination systems among MCOs and providers to reduce fragmentation and improve member engagement; and
- Data-driven reduction of non-emergency transportation costs and missed appointments, which historically total tens of millions annually according to internal BMS estimates.[10]

Evaluations by associations such as the American Medical Association (AMA) and trade-groups demonstrate that telehealth systems in primary care and behavioral health can reduce no-show appointments, enhance disease-management engagement, and improve patient satisfaction.[11]

## POLICY PROPOSAL #3
## Reform Medicaid Pricing and Payment Methodologies

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### Background

West Virginia's Medicaid reimbursement environment remains complex, with legacy methodologies and inconsistent rate structures that vary by service type and region. Many of the rate inconsistencies stem from successful lobbying efforts by various interest groups. These inconsistencies increase administrative burden, complicate rate forecasting, and create challenges in monitoring fiscal performance. Rather than eliminating negotiated provider rates, modernization efforts should focus on improving transparency, documentation, and accountability within existing state-based rate frameworks that serve as the baseline for rate-setting and rate negotiations with providers.

### National Context

The Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended stronger transparency and standardized documentation for managed care state-directed payments to improve fiscal oversight, support equity analyses, and ensure compliance

[10] West Virginia Department of Health and Human Services, Bureau for Medical Services. *Non-Emergency Medical Transportation Program Report, FY2023.* Charleston, WV, 2023.
[11] American Medical Association (AMA). *Telehealth Impact Report 2022: Expanding access, coverage, and payment.* Chicago, IL: AMA, 2022. Available at: https://www.ama-assn.org/system/files/ama-telehealth-impact-report.pdf.

with federal reporting requirements.[12] Several states—including Kentucky, Oklahoma, and North Carolina—have advanced pricing reforms by adopting consistent rate-development templates, inter-agency alignment reviews, and public documentation standards. These models maintain MCO flexibility to negotiate provider-specific rates while enhancing accountability and comparability across systems.

In May 2024, CMS issued its *Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F)*, reinforcing federal expectations for transparency, actuarial soundness, and rate justification within Medicaid managed care.[13] CMS also continues to update its annual *Managed Care Rate Development Guides* to ensure state-submitted rates are consistent, well-documented, and equitable.[14]

**West Virginia Application**

To strengthen fiscal stewardship while preserving provider autonomy, West Virginia could establish a Medicaid Pricing Transparency Initiative that would:

- Develop standardized documentation and justification templates for rate-setting and payment methodologies;
- Enhance public access to rate methodology documentation to align with federal transparency standards; and
- Coordinate periodic cross-agency rate alignment assessments to identify areas for efficiency while maintaining local flexibility.

This reform would preserve negotiated, market-based provider rates while ensuring Medicaid pricing practices are transparent, data-driven, and fiscally sustainable—consistent with federal guidance and best practices from peer states.

[12] MACPAC. *Chapter 2: Oversight of Managed Care Directed Payments.* June 2022 Report to Congress on Medicaid and CHIP. Washington, DC: MACPAC, 2022. Available at: https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-2-Oversight-of-Managed-Care-Directed-Payments-1.pdf.

[13] Centers for Medicare & Medicaid Services (CMS). *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F).* May 10, 2024.

[14] Centers for Medicare & Medicaid Services (CMS). *2025-2026 Medicaid Managed Care Rate Development Guide.* Baltimore, MD: CMS, August 2025.

## POLICY PROPOSAL #4

## Reform Certified Community Behavioral Health Clinic (CCBHC) Reimbursement

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### Background

Certified Community Behavioral Health Clinics (CCBHCs) were established under federal demonstration authority in 2014 to expand access to integrated behavioral health services for individuals with mental health and substance use disorders. West Virginia authorized participation in the CCBHC model through Senate Bill 247 (2022 Regular Session), codifying a new clinic designation under the Bureau for Behavioral Health.

According to the West Virginia Legislature's official fiscal note (2022), the Department of Health and Human Resources (DHHR)—now Department of Human Services—projected a first-year cost increase of approximately $1.125 million to implement the CCBHC program. The fiscal note further stated:

> *"This legislation potentially could have a positive fiscal impact on the Department's Office of Health Facilities and Office of Drug Control Policy (less need for commitments/services) but the Department is unable to determine the impact at this time."*[15]

The estimated cost increase applied to state general revenue funds to cover expanded staffing and reimbursement rates for CCBHC-certified providers under DHHR's Bureau for Behavioral Health.

While the CCBHC initiative was designed to improve access and care coordination, its cost-based reimbursement model has contributed to significant spending growth without clear evidence of improved outcomes. Preliminary financial and utilization analyses from West Virginia's Medicaid MCOs indicate that total behavioral health claims expenditures have increased substantially since the transition to CCBHC payment structures, while quality measures such as emergency department utilization and follow-up rates after discharge have shown limited improvement.

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[15] West Virginia Legislature. *Fiscal Note for S.B. 247 (2022 Regular Session): Establishing Certified Community Behavioral Health Clinics.* Charleston, WV, 2022. Available at: https://www.wvlegislature.gov/Fiscalnotes/FN(2)/fnsubmit_recordview1.cfm?submitID=11008&recordid=820418232.

For instance, one participating MCO reported that **total behavioral health claims costs increased by approximately $1.24 million per month in the year following CCBHC model implementation** (October 2024–September 2025) compared to the same period the prior year (October 2023–September 2024). This increase primarily reflects higher per-encounter reimbursement rates rather than an increase in member volume. Preliminary data shared by participating managed care organizations suggest an increase in behavioral health–related emergency department utilization following the CCBHC reimbursement transition; however, these findings are based on internal claims analyses and have not yet been publicly reported by the state.[16]

### National Context

A Mathematica Policy Research evaluation of the CCBHC demonstration found measurable gains in access across multiple states, but limited evidence to date on cost-effectiveness and long-term outcome improvement.[17] The National Council for Mental Wellbeing reports that some states face data-collection and payment-integration challenges as they transition to the CCBHC model.[18]

### West Virginia Application

Eliminating the current CCBHC reimbursement model would restore fiscal stability and ensure greater accountability in West Virginia's behavioral health system. Returning to a more traditional Medicaid managed care–negotiated rate structure would:

- Re-establish budget predictability for behavioral health expenditures, enabling the state to forecast costs with greater accuracy;
- Return authority over rate setting and service scope to BMS and participating MCOs, rather than allowing cost-based reimbursement to drive unchecked spending; and
- Prevent unsustainable budget growth before the program expands further without clear evidence of improved outcomes.

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[16] West Virginia Medicaid Managed Care Organizations (MCOs). *Aggregate Behavioral Health Expenditure and Utilization Data Submitted to WVAHP, 2025.* Internal analysis.

[17] Mathematica Policy Research. *Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2023.* Washington, D.C.: U.S. Department of Health & Human Services, July 25, 2024.

[18] National Council for Mental Wellbeing. *Transforming State Behavioral Health Systems: Findings from States on the Impact of CCBHC Implementation.* Arlington, VA, February 2025.

Preliminary internal analyses from West Virginia's Medicaid MCOs indicate that behavioral health spending has increased significantly under the cost-based CCBHC model, while utilization and quality indicators have remained largely unchanged.[19] These findings are consistent with national research showing that cost-based reimbursement structures—while improving access—can lead to rapid expenditure growth without proportional gains in measurable quality outcomes.[20]

By discontinuing the current CCBHC payment methodology and integrating behavioral health providers back into the managed care reimbursement framework, West Virginia can strengthen fiscal oversight, align incentives with quality, and ensure the long-term sustainability of its behavioral health system. This approach aligns with CMS's 2022 Behavioral Health Integration Strategy, which encourages states to coordinate behavioral health reform through managed care partnerships and data-driven accountability mechanisms.[21]

## POLICY PROPOSAL #5
## Commission an Independent Review of State Pharmacy Benefits

### Background

In July 2017, West Virginia removed its Medicaid pharmacy benefit from managed care and returned it to fee-for-service (FFS) administration—a process commonly known as a *pharmacy carve-out*. The stated intent was to enhance transparency and reduce costs through direct state management of drug pricing and rebate collections.

In 2019, BMS commissioned Navigant Consulting to evaluate the carve-out's first-year fiscal performance.[22] The Navigant report asserted that the state *"achieved more than $50 million in savings for plan year 2018"*; however, a closer review of the same data shows that total gross pharmacy spending actually rose—from approximately $475

[19] West Virginia Medicaid Managed Care Organizations (MCOs). *Aggregate Behavioral Health Expenditure and Utilization Data Submitted to WVAHP, 2025.* Internal analysis.
[20] Mathematica Policy Research & RAND Corporation. *Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2023.* Washington, DC: U.S. Dept. of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, July 25, 2024. Available at: https://www.aspe.hhs.gov/sites/default/files/documents/6b9cdcb7cb75ec2c59a029b40d6b2e63/ccbhc-report-congress-2023.pdf.
[21] Centers for Medicare & Medicaid Services (CMS). *Behavioral Health Integration Strategy.* Baltimore, MD: U.S. Department of Health and Human Services, 2022. Retrieved from https://www.cms.gov/files/document/cms-behavioral-health-strategy.pdf.
[22] West Virginia Bureau for Medical Services (BMS). *Pharmacy Carve-Out Implementation Report.* Prepared by Navigant Consulting, 2019.

million in 2017 (under managed care) to $570 million in 2018 (under FFS)—an increase of nearly $95 million year-over-year. The report itself notes:

> *"A comprehensive review of pricing in SFY 2018 along with managed care experience prior to SFY 2017 suggests that the current FFS arrangement is more cost-effective than the prior managed care arrangement,* ***even though actual FFS costs in SFY 2018 were significantly higher than managed care experience*** *in SFY 2017 after accounting for trend and membership differences."*[23]

Subsequent national analyses have continued to question the net fiscal value of pharmacy carve-outs, citing unanticipated rebate management inefficiencies, administrative cost increases, and limited utilization oversight compared with managed-care integration.

**National Context**

Some state analyses—including California's Medi-Cal review—indicate that while pharmacy benefit carve-outs may enhance pricing visibility, they often involve heightened administrative complexity and uncertain fiscal outcomes.[24]

The Menges Group (2021) published a 50-state review comparing Medicaid pharmacy benefit management models and concluded that states operating through managed care generally achieved lower net costs per prescription than those using FFS, after accounting for rebates and dispensing fees.[25] The report specifically cited West Virginia's carve-out as an example where "aggregate pharmacy expenditures increased materially following transition to FFS management."

**West Virginia Application**

Given the persistent debate over the fiscal and operational impact of West Virginia's pharmacy carve-out, policymakers should authorize an independent actuarial and fiscal review to assess:

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[23] West Virginia Bureau for Medical Services (BMS). *Pharmacy Carve-Out Implementation Report.* Prepared by Navigant Consulting, 2019, p. 7.

[24] California Legislative Analyst's Office. *Analysis of the Carve Out of Medi-Cal Pharmacy Services.* April 5, 2019. Sacramento, CA: LAO. Available at: https://lao.ca.gov/Publications/Report/3997.

[25] The Menges Group. *Medicaid Pharmacy Benefit Management: Cost and Quality Implications of Carve-In vs. Carve-Out Models.* Alexandria, VA: The Menges Group, 2021. Available at: https://www.themengesgroup.com/reports.

- Whether the pharmacy carve-out has achieved or exceeded its projected savings targets;
- Impacts on beneficiary access, continuity of care, and drug utilization management;
- Rebate reconciliation and pricing transparency under current FFS administration; and
- The potential benefits of reintegrating pharmacy benefits under managed-care oversight.

Such an analysis would provide objective, data-driven guidance for future contracting decisions and ensure that the Medicaid pharmacy program operates efficiently, transparently, and sustainably. The state's Medicaid MCOs have indicated their willingness to jointly fund and support this independent review to advance evidence-based policymaking.

## ADDITIONAL POLICY OPPORTUNITIES FOR CONSIDERATION

While the MMR Committee identified five primary reform priorities, several secondary opportunities for improvement emerged that merit further analysis. These issues are not immediate recommendations but represent long-term strategies that could enhance Medicaid's structural efficiency and fiscal accountability if pursued in partnership with the Bureau for Medical Services (BMS) and the West Virginia Legislature.

### ADDITIONAL OPPORTUNITY #1
### Medicaid Vendor Consolidation

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**Background**

West Virginia's Medicaid enterprise currently utilizes multiple vendors and contracted service providers for claims processing, quality measurement, care management, and information technology support. While these contracts serve discrete functions, their fragmentation creates inefficiencies, redundant administrative costs, and challenges with data integration.

### Recommendation

A comprehensive vendor mapping and consolidation study should be conducted to identify overlapping responsibilities and assess opportunities for integration under unified procurement structures. Several states—including Minnesota, Arizona, and Iowa—have implemented consolidated vendor frameworks that reduced duplicative overhead and improved interoperability among Medicaid Management Information Systems (MMIS).

### Benefits

- Improved cross-vendor data sharing and analytics.
- Reduction in administrative costs associated with overlapping contract management.
- Streamlined oversight, compliance monitoring, and performance evaluation.

Federal oversight reports note that consolidating administrative functions and modernizing Medicaid systems can reduce duplicative vendor costs, streamline oversight, and improve data integration.[26]

## ADDITIONAL OPPORTUNITY #2
## Dual-Eligible Program Integration

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### Background

"Dual-eligibles"—individuals enrolled in both Medicare and Medicaid—represent a small percentage of enrollees but a disproportionately high share of spending due to complex health needs. West Virginia's dual-eligible population is part of the larger national cohort of individuals eligible for both Medicare and Medicaid, whose high-need status and cost profile pose distinct coordination challenges for the state's Medicaid program.[27]

[26] U.S. Government Accountability Office (GAO). *Medicaid Information Technology: Opportunities Exist to Improve Oversight of State Modernization Efforts.* GAO-24-107487, April 16, 2024. Washington, DC. Available at: https://www.gao.gov/assets/gao-24-107487.pdf.
[27] Medicaid and CHIP Payment and Access Commission (MACPAC). *MACStats: Medicaid and CHIP Data Book.* December 2024. Available at: https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf.

Despite their high utilization of services, these members often experience fragmented care delivery between federally administered Medicare benefits and state-managed Medicaid services, resulting in care gaps, duplicative spending, and limited accountability for outcomes[28].

**Recommendation**

West Virginia should explore Medicare-Medicaid integration models that align incentives and coordinate care delivery, such as:

- Fully Integrated Dual Eligible (FIDE) Special Needs Plans (SNPs) — which integrate both Medicare and Medicaid benefits, financing, and care coordination under a single managed care organization; and
- Highly Integrated Dual Eligible (HIDE) SNPs — which align but do not fully integrate financing, serving as a transitional model toward full integration.

States such as Ohio (MyCare Ohio) and Massachusetts (One Care) are advancing integrated dual-eligible care models under FIDE SNP frameworks, aimed at improving care coordination, reducing institutional use, and enhancing member experience.[29]

Pursuing similar integration models in West Virginia could streamline oversight, reduce redundant expenditures, and enhance care quality for this high-cost population, consistent with CMS's priorities for improving care coordination and benefit alignment for dually eligible individuals.

**Benefits**

- Improved care coordination and reduced duplication of services through integrated care management structures.
- Simplified member experience by consolidating Medicare and Medicaid benefits under one coordinated entity.

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[28] Kaiser Family Foundation (KFF). *The Landscape of Medicare and Medicaid Coverage Arrangements for Dual-Eligible Individuals Across States.* January 2024. Available at: https://www.kff.org/medicare/the-landscape-of-medicare-and-medicaid-coverage-arrangements-for-dual-eligible-individuals-across-states/.

[29] Massachusetts Executive Office of Health and Human Services. *One Care Plans: External Quality Review Annual Technical Report Calendar Year 2022.* Richmond, MA: Commonwealth of Massachusetts, June 2024. Available at: https://www.mass.gov/doc/one-care-plans-annual-technical-report-calendar-year-2022/download.

- Potential reductions in per-capita spending through aligned incentives and reduced administrative complexity.
- Enhanced accountability for outcomes, as integrated plans assume responsibility for both medical and long-term care expenditures.

The Centers for Medicare & Medicaid Services continues to support state efforts to integrate care for Medicare-Medicaid enrollees through the Financial Alignment Initiative and Medicaid-Medicaid Coordination Office (MMCO) support, offering technical assistance, waiver flexibility, and tools to advance coordinated coverage.[30]

## ADDITIONAL OPPORTUNITY #3
## Benefit Alignment and Optional Service Review

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### Background

Under federal law, states are required to provide a set of "mandatory" Medicaid services but may also offer "optional" benefits such as adult dental, podiatry, or orthodontia. While optional services improve access, they can also increase financial pressure during budget shortfalls.

In West Virginia, the expansion of certain optional services—particularly within dental and behavioral health—has outpaced budget growth, prompting the need for a periodic benefit alignment review.

### Recommendation

A structured, periodic evaluation should be conducted to determine:

- Whether optional benefits remain cost-effective relative to utilization and outcomes.
- How coverage aligns with the state's broader health priorities.

[30] Centers for Medicare & Medicaid Services (CMS). *Financial Alignment Initiative for Medicare-Medicaid Enrollees.* Accessed Oct 31, 2025. Available at: https://www.cms.gov/medicaid-chip/medicare-coordination/financial-alignment.

- Whether benefit modifications could free resources for high-impact services such as maternal health or substance use treatment.

**Benefits**

- Better fiscal predictability for the Legislature and BMS.
- Targeted investment in high-value care services.
- Transparency for stakeholders through regular reporting and public review.

Transparency for stakeholders is improved when states establish formal review mechanisms to assess optional Medicaid benefits and publish regular reporting on alignment with program goals.

Each of these emerging opportunities represents a potential next phase in the Medicaid Made Right initiative. They are consistent with the framework—addressing Process (vendor reform), Policy (dual-eligible integration), and Price (benefit alignment). WVAHP and its member organizations recommend further study and interagency coordination to assess implementation feasibility, fiscal impact, and alignment with federal guidance.

## CONCLUSION

The Medicaid Made Right initiative reflects a unified commitment by West Virginia's managed care community to modernize and strengthen the state's Medicaid program through data-driven policy reform. The initiative's development was grounded in extensive research, stakeholder collaboration, and a clear recognition of the fiscal and operational challenges facing the program.

By aligning reforms around the three Ps—Price, Process, and Policy—MMR offers a structured, achievable framework for advancing efficiency, accountability, and quality of care. The five primary recommendations—ranging from LTSS integration to standardized pricing and independent pharmacy review—represent pragmatic solutions that can yield measurable improvements in outcomes and cost control.

Beyond these central reforms, the secondary opportunities identified—vendor consolidation, dual-eligible integration, and benefit alignment—offer additional pathways to sustainability. Together, these initiatives provide a comprehensive roadmap for transforming West Virginia Medicaid into a high-performance system capable of meeting the needs of current and future beneficiaries.

The West Virginia Association of Health Plans and its member MCOs stand ready to work collaboratively with the Bureau for Medical Services, the Governor's Office, and the West Virginia Legislature to implement these reforms. Through continued coordination, transparency, and focus on results, West Virginia can position itself as a national leader in Medicaid innovation and fiscal stewardship.

Ultimately, Medicaid Made Right is a long-term strategy to ensure that West Virginia's Medicaid program delivers the right care, at the right time, for the right cost.