Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

# State of West Virginia
# Master Agreement

**Order Date:** 01-26-2023

CORRECT ORDER NUMBER MUST APPEAR ON ALL PACKAGES, INVOICES, AND SHIPPING PAPERS. QUESTIONS CONCERNING THIS ORDER SHOULD BE DIRECTED TO THE DEPARTMENT CONTACT.

| | | | |
|---|---|---|---|
| **Order Number:** | CMA 0511 2582 BMS2300000003 1 | **Procurement Folder:** | 1052601 |
| **Document Name:** | SPECIALIZED MANAGED CARE FOR CHILDREN AND YOUTH | **Reason for Modification:** | |
| **Document Description:** | SPECIALIZED MANAGED CARE FOR CHILDREN AND YOUTH | | |
| **Procurement Type:** | Central Master Agreement | | |
| **Buyer Name:** | | | |
| **Telephone:** | | | |
| **Email:** | | | |
| **Shipping Method:** | Best Way | **Effective Start Date:** | 2023-07-01 |
| **Free on Board:** | FOB Dest, Freight Prepaid | **Effective End Date:** | 2024-06-30 |

## VENDOR

**Vendor Customer Code:** VS0000010164
COVENTRY HEALTH CARE OF WEST VIRGINIA INC
500 Virginia St E

Charleston WV 25301-2135
US
**Vendor Contact Phone:** 304-348-2041 **Extension:**

**Discount Details:**

| | Discount Allowed | Discount Percentage | Discount Days |
|---|---|---|---|
| #1 | No | 0.0000 | 0 |
| #2 | No | | |
| #3 | No | | |
| #4 | No | | |

## DEPARTMENT CONTACT

**Requestor Name:** Kelly (Jimmy) Dowden
**Requestor Phone:** (304) 356-4861
**Requestor Email:** jimmy.k.dowden@wv.gov

23
FILE LOCATION _____

## INVOICE TO

PROCUREMENT OFFICER: 304-352-4286
HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

350 CAPITOL ST, RM 251

CHARLESTON WV 25301-3709

US

## SHIP TO

PROCUREMENT OFFICER: 304-352-4286
HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

350 CAPITOL ST, RM 251

CHARLESTON WV 25301-3709

US

| **Total Order Amount:** | Open End |
|---|---|

Purchasing Division's File Copy

ENTERED

CH 2/1/23

**PURCHASING DIVISION AUTHORIZATION**
DATE:
ELECTRONIC SIGNATURE ON FILE

**ATTORNEY GENERAL APPROVAL AS TO FORM**
DATE:
ELECTRONIC SIGNATURE ON FILE

**ENCUMBRANCE CERTIFICATION**
DATE: 2/06/2023
ELECTRONIC SIGNATURE ON FILE

2/6/2023

**Extended Description:**

THE VENDOR, COVENTRY HEALTH CARE OF WEST VIRGINIA INC, DBA AETNA BETTER HEALTH OF WEST VIRGINIA, AGREES TO ENTER WITH THE AGENCY, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, INTO AN OPEN-END CONTRACT TO PROVIDE SPECIALIZED MANAGED CARE FOR CHILDREN AND YOUTH PER THE TERMS AND CONDITIONS, SPECIFICATIONS, BID REQUIREMENTS, ADDENDUM 1 ISSUED 10/17/2022, AND THE VENDOR'S PROPOSAL DATED 10/17/2022, INCORPORATED HEREIN BY REFERENCE, AND MADE A PART OF HEREOF.

| Line | Commodity Code | Manufacturer | Model No | Unit | Unit Price |
|---|---|---|---|---|---|
| 1 | 84131602 | | | | 0.000000 |
| | **Service From** | **Service To** | | **Service Contract Amount** | |
| | 2023-07-01 | 2024-06-30 | | 1069410.24 | |

**Commodity Line Description:** Administrative Services (SNS) Year 1

**Extended Description:**
Administrative Services (SNS) Year 1

## GENERAL TERMS AND CONDITIONS:

**1. CONTRACTUAL AGREEMENT:** Issuance of an Award Document signed by the Purchasing Division Director, or his designee, and approved as to form by the Attorney General's office constitutes acceptance by the State of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid, or on the Contract if the Contract is not the result of a bid solicitation, signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract.

**2. DEFINITIONS:** As used in this Solicitation/Contract, the following terms shall have the meanings attributed to them below. Additional definitions may be found in the specifications included with this Solicitation/Contract.

**2.1. "Agency"** or **"Agencies"** means the agency, board, commission, or other entity of the State of West Virginia that is identified on the first page of the Solicitation or any other public entity seeking to procure goods or services under this Contract.

**2.2. "Bid"** or **"Proposal"** means the vendors submitted response to this solicitation.

**2.3. "Contract"** means the binding agreement that is entered into between the State and the Vendor to provide the goods or services requested in the Solicitation.

**2.4. "Director"** means the Director of the West Virginia Department of Administration, Purchasing Division.

**2.5. "Purchasing Division"** means the West Virginia Department of Administration, Purchasing Division.

**2.6. "Award Document"** means the document signed by the Agency and the Purchasing Division, and approved as to form by the Attorney General, that identifies the Vendor as the contract holder.

**2.7. "Solicitation"** means the official notice of an opportunity to supply the State with goods or services that is published by the Purchasing Division.

**2.8. "State"** means the State of West Virginia and/or any of its agencies, commissions, boards, etc. as context requires.

**2.9. "Vendor"** or **"Vendors"** means any entity submitting a bid in response to the Solicitation, the entity that has been selected as the lowest responsible bidder, or the entity that has been awarded the Contract as context requires.

**3. CONTRACT TERM; RENEWAL; EXTENSION:** The term of this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below:

☑ **Term Contract**

**Initial Contract Term:** The Initial Contract Term will be for a period of one (1) year. The Initial Contract Term becomes effective on the effective start date listed on the first page of this Contract, identified as the State of West Virginia contract cover page containing the signatures of the Purchasing Division, Attorney General, and Encumbrance clerk (or another page identified as _____), and the Initial Contract Term ends on the effective end date also shown on the first page of this Contract.

**Renewal Term:** This Contract may be renewed upon the mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any request for renewal should be delivered to the Agency and then submitted to the Purchasing Division thirty (30) days prior to the expiration date of the initial contract term or appropriate renewal term. A Contract renewal shall be in accordance with the terms and conditions of the original contract. Unless otherwise specified below, renewal of this Contract is limited to three (3) successive one (1) year periods or multiple renewal periods of less than one year, provided that the multiple renewal periods do not exceed the total number of months available in all renewal years combined. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's office (Attorney General approval is as to form only)

☐ **Alternate Renewal Term** – This contract may be renewed for _____ successive _____ year periods or shorter periods provided that they do not exceed the total number of months contained in all available renewals. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's office (Attorney General approval is as to form only)

**Delivery Order Limitations:** In the event that this contract permits delivery orders, a delivery order may only be issued during the time this Contract is in effect. Any delivery order issued within one year of the expiration of this Contract shall be effective for one year from the date the delivery order is issued. No delivery order may be extended beyond one year after this Contract has expired.

☐ **Fixed Period Contract:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and must be completed within _____days.

☐ **Fixed Period Contract with Renewals:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and part of the Contract more fully described in the attached specifications must be completed within _____ days. Upon completion of the work covered by the preceding sentence, the vendor agrees that:

☐ the contract will continue for _____ years;

☐ the contract may be renewed for _____ successive _____ year periods or shorter periods provided that they do not exceed the total number of months contained in all available renewals. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's Office (Attorney General approval is as to form only).

☐ **One-Time Purchase:** The term of this Contract shall run from the issuance of the Award Document until all of the goods contracted for have been delivered, but in no event will this Contract extend for more than one fiscal year.

☐ **Construction/Project Oversight:** This Contract becomes effective on the effective start date listed on the first page of this Contract, identified as the State of West Virginia contract cover page containing the signatures of the Purchasing Division, Attorney General, and Encumbrance clerk (or another page identified as _____), and continues until the project for which the vendor is providing oversight is complete.

☐ **Other:** Contract Term specified in _____

**4. AUTHORITY TO PROCEED:** Vendor is authorized to begin performance of this contract on the date of encumbrance listed on the front page of the Award Document unless either the box for "Fixed Period Contract" or "Fixed Period Contract with Renewals" has been checked in Section 3 above. If either "Fixed Period Contract" or "Fixed Period Contract with Renewals" has been checked, Vendor must not begin work until it receives a separate notice to proceed from the State. The notice to proceed will then be incorporated into the Contract via change order to memorialize the official date that work commenced.

**5. QUANTITIES:** The quantities required under this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below.

☐ **Open End Contract:** Quantities listed in this Solicitation/Award Document are approximations only, based on estimates supplied by the Agency. It is understood and agreed that the Contract shall cover the quantities actually ordered for delivery during the term of the Contract, whether more or less than the quantities shown.

☑ **Service:** The scope of the service to be provided will be more clearly defined in the specifications included herewith.

☐ **Combined Service and Goods:** The scope of the service and deliverable goods to be provided will be more clearly defined in the specifications included herewith.

☐ **One-Time Purchase:** This Contract is for the purchase of a set quantity of goods that are identified in the specifications included herewith. Once those items have been delivered, no additional goods may be procured under this Contract without an appropriate change order approved by the Vendor, Agency, Purchasing Division, and Attorney General's office.

☐ **Construction:** This Contract is for construction activity more fully defined in the specifications.

**6. EMERGENCY PURCHASES:** The Purchasing Division Director may authorize the Agency to purchase goods or services in the open market that Vendor would otherwise provide under this Contract if those goods or services are for immediate or expedited delivery in an emergency. Emergencies shall include, but are not limited to, delays in transportation or an unanticipated increase in the volume of work. An emergency purchase in the open market, approved by the Purchasing Division Director, shall not constitute of breach of this Contract and shall not entitle the Vendor to any form of compensation or damages. This provision does not excuse the State from fulfilling its obligations under a One-Time Purchase contract.

**7. REQUIRED DOCUMENTS:** All of the items checked in this section must be provided to the Purchasing Division by the Vendor as specified:

☑ **LICENSE(S) / CERTIFICATIONS / PERMITS:** In addition to anything required under the Section of the General Terms and Conditions entitled Licensing, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits upon request and in a form acceptable to the State. The request may be prior to or after contract award at the State's sole discretion.

☑ Certificate of Authority issued by the WV Offices of the Insurance Commissioner (prior to contract start date)

☑ NCQA accreditation (prior to contract start date)

☑ Provider network certification (prior to contract start date)

☑ All other required materials as outlined within the Service Provider Agreement and/or RFP

The apparent successful Vendor shall also furnish proof of any additional licenses or certifications contained in the specifications regardless of whether or not that requirement is listed above.

**8. INSURANCE:** The apparent successful Vendor shall furnish proof of the insurance identified by a checkmark below prior to Contract award. The insurance coverages identified below must be maintained throughout the life of this contract. Thirty (30) days prior to the expiration of the insurance policies, Vendor shall provide the Agency with proof that the insurance mandated herein has been continued. Vendor must also provide Agency with immediate notice of any changes in its insurance policies, including but not limited to, policy cancelation, policy reduction, or change in insurers. The apparent successful Vendor shall also furnish proof of any additional insurance requirements contained in the specifications prior to Contract award regardless of whether that insurance requirement is listed in this section.

Vendor must maintain:

☑ **Commercial General Liability Insurance** in at least an amount of: $1,000,000.00 per occurrence.

☑ **Automobile Liability Insurance** in at least an amount of: $1,000,000.00 per occurrence.

☑ **Professional/Malpractice/Errors and Omission Insurance** in at least an amount of: $1,000,000.00 per occurrence. Notwithstanding the forgoing, Vendor's are not required to list the State as an additional insured for this type of policy.

☐ **Commercial Crime and Third Party Fidelity Insurance** in an amount of: _____ per occurrence.

☑ **Cyber Liability Insurance** in an amount of: $1,000,000.00 per occurrence.

☐ **Builders Risk Insurance** in an amount equal to 100% of the amount of the

Contract. [ ] **Pollution Insurance** in an amount of: _____ per

☐currence.

☐ **Aircraft Liability** in an amount of: _____ per occurrence.

☑ Worker's Compensation - $2,000,000.00 per each accident.

☑ ***INSURANCE CERTIFICATE HOLDER SHOULD READ AS FOLLOWS:
WV DHHR
350 CAPITOL ST, RM 251, CHARLESTON, WV 25301

☐

☐

**9. WORKERS' COMPENSATION INSURANCE:** Vendor shall comply with laws relating to workers compensation, shall maintain workers' compensation insurance when required, and shall furnish proof of workers' compensation insurance upon request.

**10. VENUE:** All legal actions for damages brought by Vendor against the State shall be brought in the West Virginia Claims Commission. Other causes of action must be brought in the West Virginia court authorized by statute to exercise jurisdiction over it.

**11. LIQUIDATED DAMAGES:** This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue any other available remedy. Vendor shall pay liquidated damages in the amount specified below or as described in the specifications:

☐ _____ for _____.

☑ Liquidated Damages Contained in the Specifications.

☐ Liquidated Damages Are Not Included in this Contract.

**12. ACCEPTANCE:** Vendor's signature on its bid, or on the certification and signature page, constitutes an offer to the State that cannot be unilaterally withdrawn, signifies that the product or service proposed by vendor meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise indicated, and signifies acceptance of the terms and conditions contained in the Solicitation unless otherwise indicated.

**13. PRICING:** The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification. Notwithstanding the foregoing, Vendor must extend any publicly advertised sale price to the State and invoice at the lower of the contract price or the publicly advertised sale price.

**14. PAYMENT IN ARREARS:** Payments for goods/services will be made in arrears only upon receipt of a proper invoice, detailing the goods/services provided or receipt of the goods/services, whichever is later. Notwithstanding the foregoing, payments for software maintenance, licenses, or subscriptions may be paid annually in advance.

**15. PAYMENT METHODS:** Vendor must accept payment by electronic funds transfer and P-Card. (The State of West Virginia's Purchasing Card program, administered under contract by a banking institution, processes payment for goods and services through state designated credit cards.)

**16. TAXES:** The Vendor shall pay any applicable sales, use, personal property or any other taxes arising out of this Contract and the transactions contemplated thereby. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

**17. ADDITIONAL FEES:** Vendor is not permitted to charge additional fees or assess additional charges that were not either expressly provided for in the solicitation published by the State of West Virginia, included in the Contract, or included in the unit price or lump sum bid amount that Vendor is required by the solicitation to provide. Including such fees or charges as notes to the solicitation may result in rejection of vendor's bid. Requesting such fees or charges be paid after the contract has been awarded may result in cancellation of the contract.

**18. FUNDING:** This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made available. If that occurs, the State may notify the Vendor that an alternative source of funding has been obtained and thereby avoid the automatic termination. Non-appropriation or non-funding shall not be considered an event of default.

**19. CANCELLATION:** The Purchasing Division Director reserves the right to cancel this Contract immediately upon written notice to the vendor if the materials or workmanship supplied do not conform to the specifications contained in the Contract. The Purchasing Division Director may also cancel any purchase or Contract upon 30 days written notice to the Vendor in accordance with West Virginia Code of State Rules § 148-1-5.2.b.

**20. TIME:** Time is of the essence regarding all matters of time and performance in this Contract.

**21. APPLICABLE LAW:** This Contract is governed by and interpreted under West Virginia law without giving effect to its choice of law principles. Any information provided in specification manuals, or any other source, verbal or written, which contradicts or violates the West Virginia Constitution, West Virginia Code, or West Virginia Code of State Rules is void and of no effect.

**22. COMPLIANCE WITH LAWS:** Vendor shall comply with all applicable federal, state, and local laws, regulations and ordinances. By submitting a bid, Vendor acknowledges that it has reviewed, understands, and will comply with all applicable laws, regulations, and ordinances.

> **SUBCONTRACTOR COMPLIANCE:** Vendor shall notify all subcontractors providing commodities or services related to this Contract that as subcontractors, they too are required to comply with all applicable laws, regulations, and ordinances. Notification under this provision must occur prior to the performance of any work under the contract by the subcontractor.

**23. ARBITRATION:** Any references made to arbitration contained in this Contract, Vendor's bid, or in any American Institute of Architects documents pertaining to this Contract are hereby deleted, void, and of no effect.

**24. MODIFICATIONS:** This writing is the parties' final expression of intent. Notwithstanding anything contained in this Contract to the contrary no modification of this Contract shall be binding without mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any change to existing contracts that adds work or changes contract cost, and were not included in the original contract, must be approved by the Purchasing Division and the Attorney General's Office (as to form) prior to the implementation of the change or commencement of work affected by the change.

**25. WAIVER:** The failure of either party to insist upon a strict performance of any of the terms or provision of this Contract, or to exercise any option, right, or remedy herein contained, shall not be construed as a waiver or a relinquishment for the future of such term, provision, option, right, or remedy, but the same shall continue in full force and effect. Any waiver must be expressly stated in writing and signed by the waiving party.

**26. SUBSEQUENT FORMS:** The terms and conditions contained in this Contract shall supersede any and all subsequent terms and conditions which may appear on any form documents submitted by Vendor to the Agency or Purchasing Division such as price lists, order forms, invoices, sales agreements, or maintenance agreements, and includes internet websites or other electronic documents. Acceptance or use of Vendor's forms does not constitute acceptance of the terms and conditions contained thereon.

**27. ASSIGNMENT:** Neither this Contract nor any monies due, or to become due hereunder, may be assigned by the Vendor without the express written consent of the Agency, the Purchasing Division, the Attorney General's office (as to form only), and any other government agency or office that may be required to approve such assignments.

**28. WARRANTY:** The Vendor expressly warrants that the goods and/or services covered by this Contract will: (a) conform to the specifications, drawings, samples, or other description furnished or specified by the Agency; (b) be merchantable and fit for the purpose intended; and (c) be free from defect in material and workmanship.

**29. STATE EMPLOYEES:** State employees are not permitted to utilize this Contract for personal use and the Vendor is prohibited from permitting or facilitating the same.

**30. PRIVACY, SECURITY, AND CONFIDENTIALITY:** The Vendor agrees that it will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the Agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the Agency's policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/default.html.

**31. YOUR SUBMISSION IS A PUBLIC DOCUMENT:** Vendor's entire response to the Solicitation and the resulting Contract are public documents. As public documents, they will be disclosed to the public following the bid/proposal opening or award of the contract, as required by the competitive bidding laws of West Virginia Code §§ 5A-3-1 et seq., 5-22-1 et seq., and 5G-1-1 et seq. and the Freedom of Information Act West Virginia Code §§ 29B-1-1 et seq.

DO NOT SUBMIT MATERIAL YOU CONSIDER TO BE CONFIDENTIAL, A TRADE SECRET, OR OTHERWISE NOT SUBJECT TO PUBLIC DISCLOSURE.

Submission of any bid, proposal, or other document to the Purchasing Division constitutes your explicit consent to the subsequent public disclosure of the bid, proposal, or document. The Purchasing Division will disclose any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to include any "trade secrets" as defined by West Virginia Code § 47-22-1 et seq. All submissions are subject to public disclosure without notice.

**32. LICENSING:** In accordance with West Virginia Code of State Rules § 148-1-6.1.e, Vendor must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agency or political subdivision. Obligations related to political subdivisions may include, but are not limited to, business licensing, business and occupation taxes, inspection compliance, permitting, etc. Upon request, the Vendor must provide all necessary releases to obtain information to enable the Purchasing Division Director or the Agency to verify that the Vendor is licensed and in good standing with the above entities.

**SUBCONTRACTOR COMPLIANCE:** Vendor shall notify all subcontractors providing commodities or services related to this Contract that as subcontractors, they too are required to be licensed, in good standing, and up-to-date on all state and local obligations as described in this section. Obligations related to political subdivisions may include, but are not limited to, business licensing, business and occupation taxes, inspection compliance, permitting, etc. Notification under this provision must occur prior to the performance of any work under the contract by the subcontractor.

**33. ANTITRUST:** In submitting a bid to, signing a contract with, or accepting a Award Document from any agency of the State of West Virginia, the Vendor agrees to convey, sell, assign, or transfer to the State of West Virginia all rights, title, and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to Vendor.

**34. VENDOR NON-CONFLICT:** Neither Vendor nor its representatives are permitted to have any interest, nor shall they acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency.

**35. VENDOR RELATIONSHIP:** The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by this Contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents. Vendor shall be responsible for selecting, supervising, and compensating any and all individuals employed pursuant to the terms of this Solicitation and resulting contract. Neither the Vendor, nor any employees or subcontractors of the Vendor, shall be deemed to be employees of the State for any purpose whatsoever. Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension, or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, licensing fees, etc. and the filing of all necessary documents, forms, and returns pertinent to all of the foregoing.

Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, Social Security taxes, and employer income tax returns.

**36. INDEMNIFICATION:** The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the Contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

**37. NO DEBT CERTIFICATION:** In accordance with West Virginia Code §§ 5A-3-10a and 5-22-1(i), the State is prohibited from awarding a contract to any bidder that owes a debt to the State or a political subdivision of the State. By submitting a bid, or entering into a contract with the State, Vendor is affirming that (1) for construction contracts, the Vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, neither the Vendor nor any related party owe a debt as defined above, and neither the Vendor nor any related party are in employer default as defined in the statute cited above unless the debt or employer default is permitted under the statute.

**38. CONFLICT OF INTEREST:** Vendor, its officers or members or employees, shall not presently have or acquire an interest, direct or indirect, which would conflict with or compromise the performance of its obligations hereunder. Vendor shall periodically inquire of its officers, members and employees to ensure that a conflict of interest does not arise. Any conflict of interest discovered shall be promptly presented in detail to the Agency.

**39. REPORTS:** Vendor shall provide the Agency and/or the Purchasing Division with the following reports identified by a checked box below:

☑ Such reports as the Agency and/or the Purchasing Division may request. Requested reports may include, but are not limited to, quantities purchased, agencies utilizing the contract, total contract expenditures by agency, etc.

☐ Quarterly reports detailing the total quantity of purchases in units and dollars, along with a listing of purchases by agency. Quarterly reports should be delivered to the Purchasing Division via email at purchasing.division@wv.gov.

**40. BACKGROUND CHECK:** In accordance with W. Va. Code § 15-2D-3, the State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check. Service providers should contact the West Virginia Division of Protective Services by phone at (304) 558-9911 for more information.

**41. PREFERENCE FOR USE OF DOMESTIC STEEL PRODUCTS:** Except when authorized by the Director of the Purchasing Division pursuant to W. Va. Code § 5A-3-56, no contractor may use or supply steel products for a State Contract Project other than those steel products made in the United States. A contractor who uses steel products in violation of this section may be subject to civil penalties pursuant to W. Va. Code § 5A-3-56. As used in this section:

a. "State Contract Project" means any erection or construction of, or any addition to, alteration of or other improvement to any building or structure, including, but not limited to, roads or highways, or the installation of any heating or cooling or ventilating plants or other equipment, or the supply of and materials for such projects, pursuant to a contract with the State of West Virginia for which bids were solicited on or after June 6, 2001.

b. "Steel Products" means products rolled, formed, shaped, drawn, extruded, forged, cast, fabricated or otherwise similarly processed, or processed by a combination of two or more or such operations, from steel made by the open heath, basic oxygen, electric furnace, Bessemer or other steel making process.

c. The Purchasing Division Director may, in writing, authorize the use of foreign steel products if:

    1. The cost for each contract item used does not exceed one tenth of one percent (.1%) of the total contract cost or two thousand five hundred dollars ($2,500.00), whichever is greater. For the purposes of this section, the cost is the value of the steel product as delivered to the project; or

    2. The Director of the Purchasing Division determines that specified steel materials are not produced in the United States in sufficient quantity or otherwise are not reasonably available to meet contract requirements.

**42. PREFERENCE FOR USE OF DOMESTIC ALUMINUM, GLASS, AND STEEL:** In Accordance with W. Va. Code § 5-19-1 et seq., and W. Va. CSR § 148-10-1 et seq., for every contract or subcontract, subject to the limitations contained herein, for the construction, reconstruction, alteration, repair, improvement or maintenance of public works or for the purchase of any item of machinery or equipment to be used at sites of public works, only domestic aluminum, glass or steel products shall be supplied unless the spending officer determines, in writing, after the receipt of offers or bids, (1) that the cost of domestic aluminum, glass or steel products is unreasonable or inconsistent with the public interest of the State of West Virginia, (2) that domestic aluminum, glass or steel products are not produced in sufficient quantities to meet the contract requirements, or (3) the available domestic aluminum, glass, or steel do not meet the contract specifications. This provision only applies to public works contracts awarded in an amount more than fifty thousand dollars ($50,000) or public works contracts that require more than ten thousand pounds of steel products.

The cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than twenty percent (20%) of the bid or offered price for foreign made aluminum, glass, or steel products. If the domestic aluminum, glass or steel products to be supplied or produced in a "substantial labor surplus area", as defined by the United States Department of Labor, the cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than thirty percent (30%) of the bid or offered price for foreign made aluminum, glass, or steel products. This preference shall be applied to an item of machinery or equipment, as indicated above, when the item is a single unit of equipment or machinery manufactured primarily of aluminum, glass or steel, is part of a public works contract and has the sole purpose or of being a permanent part of a single public works project. This provision does not apply to equipment or machinery purchased by a spending unit for use by that spending unit and not as part of a single public works project.

All bids and offers including domestic aluminum, glass or steel products that exceed bid or offer prices including foreign aluminum, glass or steel products after application of the preferences provided in this provision may be reduced to a price equal to or lower than the lowest bid or offer price for foreign aluminum, glass or steel products plus the applicable preference. If the reduced bid or offer prices are made in writing and supersede the prior bid or offer prices, all bids or offers, including the reduced bid or offer prices, will be reevaluated in accordance with this rule.

**43. INTERESTED PARTY SUPPLEMENTAL DISCLOSURE:** W. Va. Code § 6D-1-2 requires that for contracts with an actual or estimated value of at least $1 million, the Vendor must submit to the Agency a disclosure of interested parties prior to beginning work under this Contract. Additionally, the Vendor must submit a supplemental disclosure of interested parties reflecting any new or differing interested parties to the contract, which were not included in the original pre-work interested party disclosure, within 30 days following the completion or termination of the contract. A copy of that form is included with this solicitation or can be obtained from the WV Ethics Commission. This requirement does not apply to publicly traded companies listed on a national or international stock exchange. A more detailed definition of interested parties can be obtained from the form referenced above.

**44. PROHIBITION AGAINST USED OR REFURBISHED:** Unless expressly permitted in the solicitation published by the State, Vendor must provide new, unused commodities, and is prohibited from supplying used or refurbished commodities, in fulfilling its responsibilities under this Contract.

**45. VOID CONTRACT CLAUSES:** This Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law.

**46. ISRAEL BOYCOTT:** Bidder understands and agrees that, pursuant to W. Va. Code § 5A-3-63, it is prohibited from engaging in a boycott of Israel during the term of this contract.

**DESIGNATED CONTACT:** Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

(Printed Name and Title) Todd White, Chief Executive Officer

(Address) 500 Virginia Street East, Suite 400, Charleston, WV 25301

(Phone Number) / (Fax Number) 304-348-2041 / 959-282-1026

(email address) twhite@aetna.com

**CERTIFICATION AND SIGNATURE:** By signing below, or submitting documentation through wvOASIS, I certify that: I have reviewed this Solicitation/Contract in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation/Contract for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that this bid or offer was made without prior understanding, agreement, or connection with any entity submitting a bid or offer for the same material, supplies, equipment or services; that this bid or offer is in all respects fair and without collusion or fraud; that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; that I am authorized by the Vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on Vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

*By signing below, I further certify that I understand this Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law; and that pursuant to W. Va. Code 5A-3-63, the entity entering into this contract is prohibited from engaging in a boycott against Israel.*

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
(Company)

(Signature of Authorized Representative)

Todd White, Chief Executive Officer 10-17-22
(Printed Name and Title of Authorized Representative) (Date)

304-348-2041 / 959-282-1026
(Phone Number) (Fax Number)

twhite@aetna.com
(Email Address)

# ATTACHMENT C: PROJECT ORGANIZATION AND STAFFING APPROACH

Instructions: The Vendor is to employ staffing strategies to ensure all requirements and service levels are met to the Department's satisfaction. The evaluation of the Vendor's staffing approach shall be based on the ability of the Vendor to satisfy the requirements stated herein. Therefore, the Vendor should present detailed information regarding the expertise of the proposed staff and an Initial Staffing Plan.

For ease of formatting and evaluation, *Attachment C: Project Organization and Staffing Approach* provides the required outline for the Vendor's response to staffing. The Vendor's response to the following should not exceed 25 pages, excluding key personnel resumes, the forms provided in this Attachment, and any supplemental documentation requested as part of the submission.

Please refer to *Appendix 2: Staff Qualifications, Experience, and Responsibilities* of the RFP for details pertaining to staff qualifications, experience, and responsibilities.

## 1. Initial Staffing Plan

As part of the Vendor's bid response, the Vendor should provide an Initial Staffing Plan. In addition to the requirements described in *Attachment D: Mandatory Requirements* and *Appendix 1: Detailed Specifications*, the Vendor's narrative description of its proposed Initial Staffing Plan should include the following:

- A succinct description of the Vendor's proposed project team that should exhibit the Vendor's ability and capability to provide knowledgeable, skilled, and experienced personnel to accomplish the scope of work (SOW) as described in this RFP
- A detailed proposal for providing all resources necessary to fulfill the requirements as specified in this RFP. This includes details covering not only key staff, but also support staff
- An organizational chart showing the corporate structure, lines of responsibility, and authority in the administration of the Vendor's business as a health plan
- An organizational chart showing:
    - The organizational structure for this project and how it relates to the proposed service area(s), including staffing and functions performed at the local level
    - As available, the names, titles, and contact information for the key staff positions or functions listed in *Appendix 2: Staff Qualifications, Experience, and Responsibilities*. If any individuals are to be hired in the future, provide an approximate timeline for appointment
    - The reporting relationships of each individual listed
    - The city and state where each position will be located
    - Whether the Vendor plans to co-locate a liaison within the Department, and if so, which position(s) the Vendor proposes to fulfill this liaison role
    - Identification of Subcontractor staff, if applicable
- An organizational chart showing how Subcontractor(s) will be managed within the Vendor's West Virginia organizational structure, including the primary individuals at the Vendor's organization and at each Subcontractor organization responsible for overseeing such

subcontract. This information may be included in the West Virginia organizational chart listed previously or as a separate organizational chart(s)

- A brief narrative explaining the submitted organizational charts, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the Vendor's proposed management of the Vendor program(s)
- A narrative describing tools and processes used to screen available staff to fill positions
- A narrative describing the process for replacing key staff within defined time frames, and procedures for backfilling key staff during any transition
- A hiring plan for administration of the contract awarded through this solicitation
- Information on how Vendor staffing numbers will reflect adequate access to service children in foster care and other populations indicated in this solicitation
- Subcontractor Monitoring Plan:
    - If the Vendor retains a Subcontractor for claims processing, dental benefit management (DBM), behavioral health management, utilization management, or network development, describe activities and monitoring tools for each Subcontractor. Note: CSED administration cannot be subcontracted.
    - Provide sample Subcontractor agreements for review. The winning Vendor will submit finalized agreements to the Department for approval prior to implementation
    - If contracting with a benefits manager, provide a separate listing/table of benefit manager vs. Vendor functions in administering the benefits (e.g., provider recruitment, member and provider calls, utilization management, provider education)
    - Identify the frequency of contact/status calls with each Subcontractor upon go-live and on an ongoing basis
    - Describe a plan that will be followed in the event that a Subcontractor does not fulfill its contract or service obligations, including, but not limited to, details on any corrective action plan processes
    - Describe the Vendor's contingency plan in the event that the Vendor or a Subcontractor terminates its contract, including plans to identify another Subcontractor and transition steps that would take place to ensure uninterrupted member access
    - Describe whether each Subcontractor is an affiliate of the Vendor or an unrelated third party

# Department of Health and Human Resources

## 2. USE OF DEPARTMENT STAFF

Describe the required staffing of business and technical resources the Department should provide to support the Vendor. Specifically, the Vendor should address the following:

- The nature and extent of Department support required, in terms of staff roles and percentage of time available
- Assistance from Department staff and the experience and qualification levels of required staffing for both implementation and operations phases

The Department may not be able or willing to provide the additional support the Vendor lists in this part of its proposal. Therefore, the Vendor should indicate whether its request for additional support is a requirement for its performance. If any part of the list is a requirement, the Department may reject the Vendor's proposal, if the Department is unwilling or unable to meet the requirements.

## 3. KEY STAFF AND RESUMES

Key staff consist of the Vendor's senior leadership for the Mountain Health Promise program. These resources are responsible for providing leadership and creating the standards and processes required for the successful implementation, operation, and maintenance of the program. Key staff are required to report to the CEO who will be based in West Virginia. Resumes for key staff named in the Vendor proposal should indicate the role of the staff on the Mountain Health Promise program and demonstrate how each staff member's experience and education will contribute to successful implementation and operations. Please elaborate on any staff members' experience and/or education related to the covered populations and/or covered benefits and services, where applicable. The Vendor's proposed key staff should be available for an in-person interview upon the Department's request. To ensure successful operations for this contract, the project should be led by key staff identified in the list below:

- Contract Liaison/Medicaid Administrator
- Chief Financial Officer
- Medical Director
- Medical Management Director
- Care Management Director
- Behavioral Health Medical Director
- Social Services Director
- SNS Liaison
- Quality Director

- Member Services Director
- Claims Payment Director
- Network Development Director
- Provider Relations Director
- Program Integrity Lead
- Information Technology Director
- Community Engagement Director
- Dental Director
- Medicaid Member Advocate
- CSED Director

The qualifications, experience, and responsibilities for each key staff role are defined in *Appendix 2: Staff Qualifications, Experience, and Responsibilities*.

## 3.1 Resumes

The Vendor should complete Table 12 and embed resumes of all proposed key staff to this section of the proposal. Each resume should demonstrate experience relevant to the position proposed. If applicable, resume should include work on projects cited under the Vendor's corporate experience, and the specific functions performed on such projects. This section should include the following:

- Resumes (not exceeding two pages each) for key staff and support staff members assigned to this project, including their licenses, credentials, and experience. The Department considers key staff resumes as a key indicator of the Vendor's understanding of the skill sets required for each staffing area.
- A letter of intent for each proposed staff member not currently employed by the Vendor. Each letter of intent should be signed by the named individual, indicating that the individual is willing to accept employment if the Vendor is awarded the contract.

**Table 12: Resumes for Proposed Key Staff**

| Name | Proposed Role | Experience in Proposed Role | Currently Employed by the Vendor? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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# Attachment C: Project Organization and Staffing Approach

**Instructions:**

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- Describe whether each Subcontractor is an affiliate of the Vendor or an unrelated third party

Aetna Better Health® of West Virginia (Aetna) is poised to continue our partnership with the West Virginia Department of Health and Human Resources (DHHR) through a comprehensive system of specialized managed care in service of vulnerable children and youth statewide. Since March 2020, we have been working alongside the DHHR to support West Virginian children's well-being in families and communities through the Mountain Health Promise program. Aetna has been a partner with the DHHR since July 1996 serving West Virginia Medicaid members through our 4-STAR NCQA accredited program. Our extensive West Virginia experience has enabled us to develop an effective approach to offer our foster care and children with serious emotional disorders (CSED) members targeted services and benefits to positively impact their quality of life. As we have proven throughout the pandemic and amid various obstacles over the years, we will continue to make advancements in collaboration with the State to promote and provide health services that improve the quality of the lives and futures of these children and youth.

## Initial staffing plan

We are a current and successful West Virginia health plan that is authentically West Virginian — shaped by state pride, deep roots, local knowledge, and strong personal connections. All key staff will remain headquartered and based in our Charleston office, with most of our support staff living and working throughout West Virginia, working face-to-face with our members and their families. As the sole provider of services today, we currently have 260 employees servicing the population covered in the Mountain Health Promise program and have worked with the DHHR to add new roles, including a **Family Connect Care Administrator**, who will serve as a foster care subject matter expert, report directly to our Contract Liaison/Medicaid Administrator, and sit in the State Commissioner's office to streamline collaboration and facilitate communication with the DHHR (BSS, BBH, and BMS).

Aetna's reputation as an **Employer of Choice** enables us to attract the most experienced, skilled, and knowledgeable candidates, as evidenced by the recognition we have received from a variety of organizations. In 2022, CVS Health was recognized as #28 on **DiversityInc's Top 50 Companies** list and was included as a **Top Company for Talent Acquisition of Women of Color** and **Top Company for Employee Resource Groups**. For the sixth year in a row, we received a **100%** score on Disability: IN's 2022 Disability Equality Index. In 2020, the US Dept of Labor awarded us the prestigious **Gold Award for Excellence in Disability Inclusion (EDI)**. CVS Health is also proud to be a partner of the Human Rights Campaign and was named a **Best Place to Work for LGBTQ+ Equality** in 2022 (scoring **100% on the Corporate Equality Index**). For our commitment to the military community, CVS Health has been named a **Military Friendly® Employer** and **Military Friendly® Spouse Employer** and was recognized on US Veterans Magazine's **'Best of the Best'** list for **Employers and Supplier**

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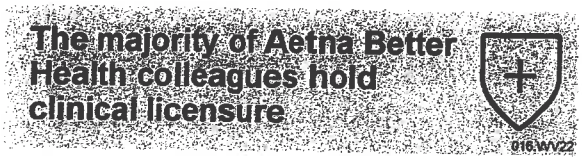
**Diversity Programs.** Additionally, Black EOE Journal most recently recognized CVS Health as a **'Best of the Best' lists for Employers, Supplier Diversity Programs, and Best LGBTQ+ Employers.** Through the high-performing people we hire, we are committed to creating an inclusive environment fueled by innovative ideas.

## Proposed project team

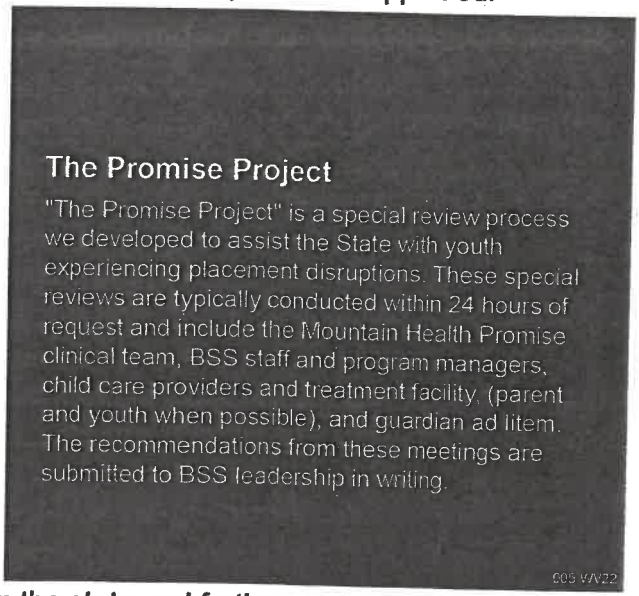



Our established project team for the Mountain Health Promise program has over **400 years' dedicated West Virginia health plan and Medicaid experience combined.** Staff experience specific to supporting children and youth who are in foster care, individuals receiving adoption assistance, and children and youth eligible for the CSED waiver is what sets us apart. This experience includes extensive expertise in substance use and trauma-informed care (TIC) as well as in-depth knowledge of child and adolescent behavioral health and corresponding evidence-based practices and interventions. In addition, Aetna's Mountain Health Promise staff are well connected in the community both personally and professionally. Many staff assist with a variety of safe, child-friendly, family-oriented events at the Marcum Terrace Family Resource Center; collaborate with State-based organizations such as Lily's Place; and chair West Virginia's Perinatal Partnership Substance Use in Pregnancy Committee.

Our project team includes highly experienced leadership with extensive local, program-specific knowledge. A detailed description highlighting all key staff knowledge and experience is listed in **Table 12** in response to Attachment C_3.

## New key staff for next phase of the contract

Aetna combined our local experience with the broader Aetna Medicaid organization's best practices to bring unique solutions to the state by adopting the **System of Care (SOC)** model. We further advanced the SOC model in West Virginia by developing our local **care advocate teams (CAT),** who work to help children and their families or caregivers create individual service plans focused on evidence-based best practices, TIC, and social determinants of health (SDoH). Five key staff positions support our specialized care management teams to better serve this population: our Contract Liaison/Medicaid Administrator, Child CAT Administrator, Adult CAT Administrator, Justice CAT Administrator, and a Recovery and Resiliency CAT Administrator. For example, Aetna's **Judicial Liaison** collaborates with our care managers to engage youth and their families prior to placement and even before transfer to Mountain Health Promise. Our Judicial Liaison works to assure the least restrictive placement to meet children's needs by locating appropriate placements for children dually involved in the child welfare and juvenile justice systems, regardless of their Medicaid status. Each of these positions are 100% dedicated to the Mountain Health Promise program to nurture our strong foster care connections in the state and further our understanding of each region's unique barriers.



Since we launched the program in March 2020, we have learned many lessons over the course of our partnership with the DHHR. For example, we are adding a new **Operations Specialist** to our Provider Support Pod who can adjudicate claims in provider offices when needed because we learned that this leads to better provider service with increased focus on quality interventions and less time on operational issues. We also learned that to impact the needs of our Mountain Health Promise members, we need to support the work of the BSS, align with our Department of Justice Agreement, continuously put **faces to the cases**, and truly develop **"The Promise Project"**. This includes the **Placement Intervention Team (PIT)** meetings, specialized clinical review meetings, and routine provider meetings with the purpose of presenting youth to the appropriate levels of care. Through these innovations, we have collaboratively worked with BSS and providers to reduce the number of youths in group residential treatment facilities from 821 in May 2022 to 662 as of October 2022, which is below the DOJ goal of 689 by December 31, 2022.

To support this population, we are committed to attracting additional professional staff with experience serving the populations covered in the Mountain Health Promise program. Our newly launched local **Aetna's Better Together: SDoH Solutions Team** establishes partnerships across the state and implements innovative solutions to address identified gaps, such as housing, food instability, employment, and education. This team is led by our Manager of Social Determinants of Health and Community Partnerships, Jordan Pruett, who is a West Virginia native and has worked in community development with Aetna in West Virginia for 10 years. His work led us to understand the importance of focusing on SDoH not only for our members, but for the benefit of the entire community. We take grassroots, boots on the ground approach, and invest our time to build strong relationships with people, organizations, and systems to improve the health and well-being of children and their families in the child welfare system.

We will also be hiring three full-time **Behavioral Health Navigators** to support our current Behavioral Health Consultant, Lora Dunn. These new employees will assist with the special reviews and outcomes, assuring Mountain Health Promise members successfully transition to the next appropriate level of care. The Behavioral Health Navigators will work with the BSS staff to gather current and accurate referral information and assure all necessary referral information is submitted to appropriate recommended providers. They will reach out to the providers to make sure all information is shared and interviews are arranged to better facilitate exchange of information and ensure prompt admission review. They will work with BSS daily to assist with moving youth who are without placement to mitigate lengths of stay at hotels and emergency departments. Behavioral Health Navigators will maintain a case load of less than eight to assure highly individualized care and allow sufficient time to meet with the youth and the youth's family and make sure their goals are relevant to the care plan. Mountain Health Promise Behavioral Health Navigators will continue to work with these members until a safe, appropriate placement is located and the member placed. Neither shelter care nor BJS would be considered to meet criteria unless the member is committed to BJS. Once a safe, appropriate place is located, the Behavioral Health Navigator will work with the Aetna Care Manager to transition the member back to the Intensive level of case management.

## Support staff

Our Mountain Health Promise support staff have extensive knowledge and experience in care management, customer service, quality improvement, clinical, special needs, and network operations, among many others. Our local leadership team is also supported by and maintains access to our national organization's Finance, Claims, Encounters, and Compliance departments, as well as our

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Special Investigations Unit (SIU). We highlight the main responsibilities of our local support staff in the table below:

**Support Staff Required to Support the Mountain Health Promise Program**

| | Role and Responsibilities to Support this Program |
|---|---|
| **Community Development Coordinator** | Develops, facilitates, and implements outreach activities, special events, programs, and presentations to support member education/health plan awareness within the Mountain Health Promise population and helps to maintain relationships with community contacts as well as adherence to marketing guidelines and compliance with State laws and regulations |
| **Supervisor, Customer Service** | Provides overall supervision of customer service staff and is accountable for member and provider satisfaction, retention, and growth by delivering competitive services to members and providers |
| **Care Management Associate** | Provides comprehensive health care management to facilitate delivery of appropriate quality health care and promotes cost-effective outcomes and improved operational efficiency involving clinical issues |
| **Contract Negotiator** | Negotiates, executes, reviews, and analyzes contracts and handles dispute resolution and settlement negotiations with smaller providers (i.e., local individual providers, small groups/systems) within company standards to maintain and enhance provider networks; meets or exceeds accessibility, compliance, quality, and financial goals and cost initiatives |
| **Clinical Liaison** | Serves as the clinical lead focusing on integrating member care and clinical coordination, leading the development, implementation, and ongoing monitoring of program and quality initiatives to address member needs; represents plan and collaborates with State government, key stakeholders, community organizations, advocacy groups, and our Chief Medical Officer/leadership team to enhance the quality of services and adherence to performance standards |
| **Case Management Coordinator** | Collaborates and inform the case management process to facilitate appropriate health care outcomes for members by providing care coordination, support, and education for members through care management tools and resources |
| **Customer Service Representative** | Serves as the face of Aetna Better Health and influences members' service experience through customer service inquiries and making sure problems via telephone, internet, or written correspondence are appropriately handled; engages, consults, and educates members based upon each member's unique needs, preferences, and understanding of plans, tools, and resources |
| **Case Manager RN** | Assesses, plans, implements, and coordinates all case management activities with members to evaluate medical needs to facilitate overall wellness; develops proactive course of action to enhance short- and long-term outcomes and enhance members' overall wellness, including providing input for strategies, policies, and programs for network management and clinical coverage policies |
| **Senior Inbound/ Outbound Queue Associate** | Supports comprehensive coordination of medical services including intake, screening, and referrals; promotes and supports quality effectiveness of health care services; serves as a training resource, mentor, and subject matter expert |
| **Manager, Clinical Health Services** | Oversees and manages clinical team processes, including the organization and development of high-performing teams |
| **Special Needs Representative** | Proactively identifies members with special needs based on referrals from within or outside the health plan; coordinates access to appropriate care and services |
| **Network Contract Specialist** | Loads, implements, and maintains standard provider contracts, schedules, and agreements and files in support of business segment contracting initiatives |
| **Health Care Quality Management Consultant** | Participates in the development and ongoing implementation of quality management (QM) work plan activities; improves quality products and services using measurement and analysis to process, evaluate, and make recommendations to meet QM goals |
| **Supervisor, Clinical Health Service** | Oversees health care management staff, including the organization and development of high-performing teams; works closely with functional area managers to ensure consistency in clinical interventions supporting Mountain Health Promise members; accountable for meeting the financial, operational, and quality objectives of the unit |
| **Network Operations Consultant** | Serves as the subject matter expert in support of contracting initiatives and data audits to enhance provider networks while meeting and exceeding accessibility, compliance, quality, and financial goals; responsible for reviewing, building, and auditing complex contract and network data; supports recruitment efforts and collaborates on negotiations as needed |
| **Outreach Coordinator, HEDIS** | Facilitates provider and member outreach to ensure member receipt of important clinical services to improve member health outcomes; provides support for Healthcare |

| Role and Responsibilities to Support this Program | |
|---|---|
| | Effectiveness Data and Information Set (HEDIS) quality initiatives and regulatory/contractual requirements, including outreach to members who are noncompliant in the designated outreach services; supports effective medical record capture for HEDIS medical record review and abstraction of supplemental data |
| **Analyst** | Gathers initial data in support of research on various projects, ensures data quality, and retrieves simple reports and/or generates standard reports for unit; assists with the analysis and collection of data |
| **Network Relations Consultant** | Acts as the primary resource for assigned, high-profile providers or groups (e.g., local individual providers, small groups/systems) to establish, oversee, and maintain positive relationships by assisting with and responding to complex issues regarding policies and procedures, plan design, contract language, service, claims, or compensation issues, and provider education needs |
| **Clinical Solutions Medical Director** | Includes internal and external-facing activities that support a shift to a higher-touch, patient-centric focus; develops, implements, supports, and promotes population health strategies, tactics, policies, and programs to drive the delivery of high-value health care; manages strategies, policies, and programs comprised of care management, utilization management, quality improvement, network management, and clinical coverage protocol; provider- and member-facing with fluency in data analytics |
| **Health Care QM Analyst** | Provides data collection and administrative/technical support to the QM staff to support QM department business plans |
| **Manager, Quality Management** | Maintains oversight of the quality management functions; consults and works cross-functionally to influence and promote change to deliver quality service to our internal and external customers |
| **Director, Clinical Pharmacy** | Develops and promotes strategies and policies that enhance quality of pharmaceutical care in a cost-effective manner |
| **Finance** | Assists in the fulfillment of the company's internal and external financial reporting obligations, internal control objectives, and financial system design and operation |
| **Complaint and Appeal Analyst** | Manages complaint and appeal resolution, which may contain multiple issues and may require coordination of responses from multiple business units; ensures timely, customer-focused response to complaints/appeals; identifies trends and emerging issues and report and recommends solutions |
| **Inbound/Outbound Queue Associate** | Supports comprehensive coordination of medical services including intake, screening, and referrals to medical services programs; promotes and supports quality effectiveness of health care services |
| **Complaint and Appeal Program Manager** | Establishes and maintains, in collaboration with all segments and business units, consistent policies and procedures defining the administration and resolution of complaints, grievances, and appeals from member and providers compliant with legislative, regulatory, and accreditation requirements; maintains infrastructure to assure ease of use and consistent resolution responses are accessible to all operational resolution teams, business units, and subject matter experts |
| **Risk Management Associate** | Manages the negotiations of self-funded agreements (i.e., administrative services agreements/master services agreements, business associate agreements), stop-loss contracts, and other special contractual arrangements and exhibits, by using delegated response databases and selectively engaging legal and financial teams and other business decisionmakers in contract negotiations when standard responses are unavailable or insufficient; develops language for those self-funded agreements/contracts based on information provided by subject matter experts and guidance by the Legal department |
| **Clinical Case Manager, Behavioral Health** | Uses advanced clinical judgment and critical thinking skills to facilitate appropriate member physical health and behavioral health care through assessment and care planning, direct provider collaboration, and coordination of psychosocial wraparound services to promote effective utilization of available resources and optimal, cost-effective outcomes |
| **Family Connect Care Administrator** | Engages with the DHHR to successfully achieve the contractual objectives of the Mountain Health Promise program; works to reduce length of stay for youth in high end residential treatment programs in and out of state; helps to increase number of CSED / home based behavioral health providers; increases the use of the FamilyConnect 2.0 portal to improve communications between Mountain Health Promise, BSS staff and providers up to 75%; supports and assists with planning and overseeing FamilyConnect 2.0 to ensure accessibility within the contractual agreement of the State, maintaining quality and using internal and external resources as necessary; supports and assists BSS with approved special projects to enhance cooperation and support for BSS staff needs |

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| Role and Responsibilities to Support this Program | |
|---|---|
| **Care Manager (Registered Nurse)** | Assesses, plans, implements, and coordinates all care management activities with members to evaluate medical needs and facilitate the member's overall wellness; develops a proactive plan to address presenting issues and enhance the short- and long-term outcomes and members' overall wellness through care integration; assigned as the Care Coordinator for members in Tier 3 intensive care management whose primary needs relate to multiple or complex chronic conditions; may act in role of crisis intervention specialist to respond within 24 or 72 hours to children who have been placed in foster care if they have 3 or more years of behavioral health experience and have had specific crisis intervention training |
| **Care Manager (Licensed BH Clinician)** | Uses advanced clinical judgment and critical thinking skills to facilitate appropriate member physical health and behavioral health care through assessment and care planning, direct provider coordination/collaboration, and coordination of psychosocial wraparound services; assigned as the Care Coordinator for members in Tier 3 intensive care management whose primary needs relate to behavioral health conditions; may act in role of crisis intervention specialist to respond within 24 or 72 hours to children who have been placed in foster care if they have 3 or more years of BH experience and have had specific crisis intervention training |
| **Peer Support Specialist** | Helps members become and stay engaged in the recovery process and reduce the likelihood of relapse by sharing of lessons learned through personally lived experience |
| **Community Health Workers (CHWs)** | Serves as a liaison between the member (community) and health/social services to improve members' navigation and access to services, benefit eligibility applications, Charting the LifeCourse care planning and goals, and accessing non-medical services; participate on the ICT as requested; educate healthcare professionals about SDoH and cultural impacts to members' health |

## Children and youth program experts provide additional support to our proposed staff

To bolster our knowledge of this unique membership population, Kevin Campbell, creator of Family Finding, provides expertise and training to all Aetna staff working within the Mountain Health Promise program. Mr. Campbell is an internationally known youth permanency expert, founder of the Center for **Family Finding and Youth Connectedness**, and developer of the Family Finding model, a set of strategies now used throughout the United States and Canada to establish lifelong supports for youth in foster care. Mountain Health Promise staff have access to a suite of Family Finding resources, designed to fit their lifestyle and level of interest, including:

- **Family Finding Bootcamp.** Sponsored by Aetna/CVS, bootcamps are three-day participatory trainings designed to teach stakeholders the Family Finding process and tools
- **Family Finding Orientation.** Aetna offers a 90-minute introductory course on Family Finding one time each month for all stakeholders needing basic information on Family Finding
- **Family Finding Coaching.** Aetna staff provide coaching upon request to BSS workers and stakeholders who are interested in learning how to begin building a network and what tools might be the most beneficial to use if the network cannot be built organically
- **Family Finding Instructional Manual.** Written by Mr. Campbell, this manual provides step-by-step instructions on using the Family Finding tools to assist in building a network for the youth and family

**Mental Health First Aid** (MHFA) training is also delivered to all West Virginia staff, including top management, as part of our standard training for all new hires. Aetna's in-house certified trainer facilitates the youth course for all attendees, taking into consideration our Mountain Health Promise population is comprised of children and young adults. The youth MHFA course is primarily intended for adults to learn how to help young people experiencing mental health challenges. It reviews the unique risk factors and warning signs of mental health problems in adolescents ages 12-18 and emphasizes the importance of early intervention.

In 2022, the Aetna Medicaid organization deployed an intensive four-day **Unifying our Culture on Anti-Biases and Equity** training to key health plan leaders on the historical context leading to health

inequities and what these leaders can do to address biases that perpetuate them. Understanding the history of discrimination, social hierarchy, and addressing underlying assumptions that drive inequities are discussed and applied to real-life, current day health concerns and policy issues.

## Providing all resources necessary to fulfill contract requirements

In collaboration with the national Aetna Medicaid organization, Aetna onboarded, has continuously employed, and will maintain a clearly defined staffing model designed to adjust to the changing needs of the State's program and RFP requirements. Our staffing plan is continuous, integrated, and scalable. It is built on the principle of **West Virginians serving West Virginians**—developing a local staff with a personal and professional passion for serving West Virginian children in foster care and similar populations, managed by key staff and health plan leaders to help ensure adequacy of staffing for a growing membership or any new contract requirements.

Aetna based the Mountain Health Promise staffing plan on our national Medicaid organization's proven operating model. This model uses a staffing ratio algorithm that continuously evaluates various factors, such as the number of projected members and unique needs of each population, to determine the number of clinical, non-clinical, and community-based support workers required to fulfill and exceed contract requirements for the program. **In 30 years, Aetna's national Medicaid organization has never failed a readiness review.** While extensive experience serving similar child and youth welfare populations in nine states across the nation drives our staffing model, we also use evidence-based guidelines built on time studies and complexity of care.

We have and will continue to exceed the requirements of West Virginia Code §9-5-27, with nearly **90% Mountain Health Promise staff residing in West Virginia**. Our project leadership actively seek West Virginians who are experienced and familiar with the local Medicaid health care delivery system and culture in the state and have the West Virginia licensures and certifications required by law and the contract. For example, we successfully recruited Kathy Szafran, the Contract Liaison/Medicaid Administrator for this program and Jennifer Eva, our CSED Director, and have remained fully staffed throughout this contract term.

## Organizational charts showing corporate structure

Aetna employs a cohesive leadership and governance structure to support the Mountain Health Promise program, based on expert personnel committed to ensuring quality and innovative programming in fulfillment of all contract requirements. The local Mountain Health Promise leadership team manages the overall delivery and operations of the program, leveraging our longstanding, positive relationships with providers, community resources, advocacy groups, regulatory agencies, and other organizations throughout the state. Aetna's leadership is empowered to make rapid-cycle decisions, ensuring timely and responsive action to consistently deliver high-quality care and services.

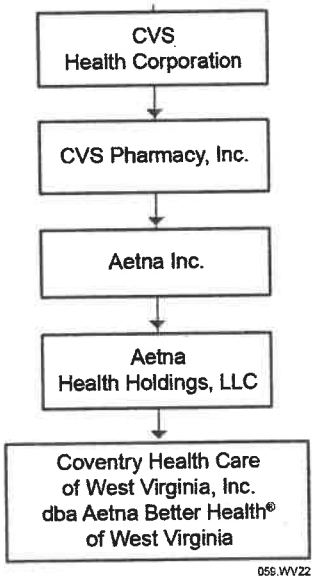


***Figure C.1-1: Aetna Better Health® of West Virginia's Corporate Structure and Lines of Authority*** *- Aetna Better Health® of West Virginia's relationship to its parent entities. Aetna Better Health® of West Virginia is a local health plan supported by national resources.*

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## Organizational chart showing project administration

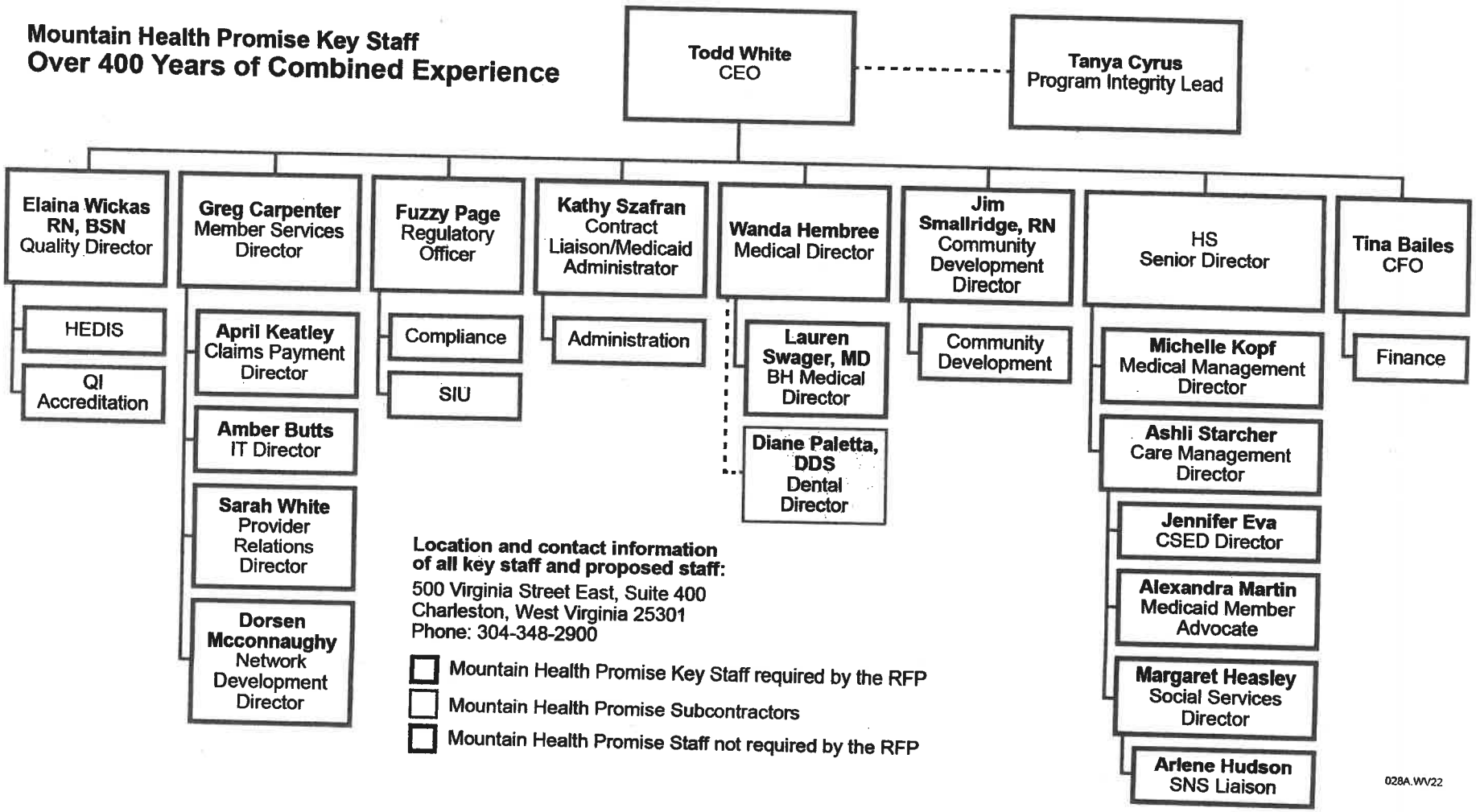


***Figure C.1-2- Aetna Better Health of West Virginia's Key Staff and Proposed Service Areas Organizational Chart*** *- Our key staff and proposed service area organizational chart emphasizes experience, accountability, and flexibility.*

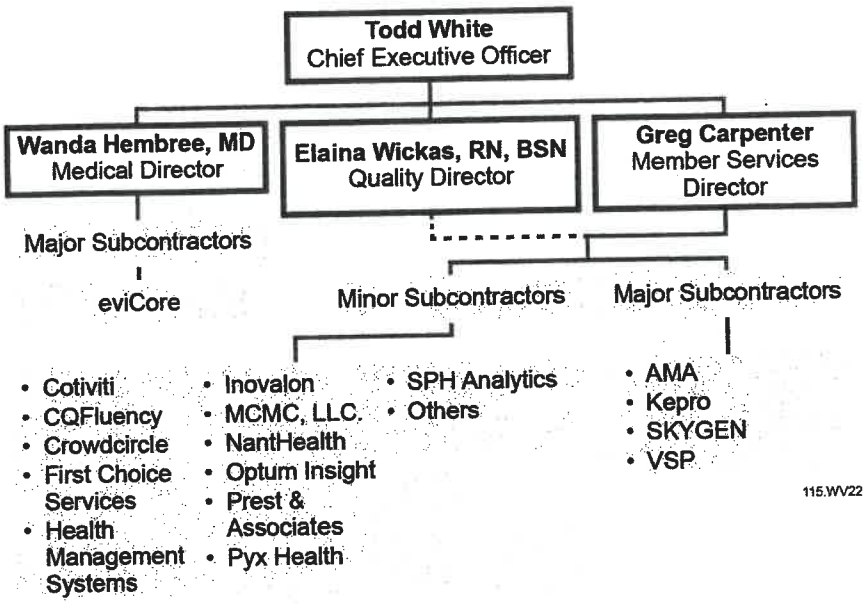


***Figure C.1-3: Aetna Better Health® of West Virginia Subcontractor Organizational Chart*** *- Our subcontractor organizational chart emphasizes oversight, accountability, compliance, and conscientious stewardship of West Virginia resources.*

## Organizational chart showing subcontractor management

### Narrative describing submitted organizational charts

**Figure C.1-1** depicts the relationship between Aetna and its parent entities. Aetna is a for-profit corporation wholly owned by Aetna Health Holdings, LLC, which is a for-profit limited liability company. Aetna Health Holdings, LLC is a wholly owned subsidiary of Aetna Inc., a for-profit corporation. Aetna Inc. is a wholly owned subsidiary of CVS Pharmacy Inc., also a for-profit corporation. CVS Pharmacy Inc. is wholly owned by CVS Health Corporation, a for-profit, publicly traded company.

**Figure C.1-2** illustrates the functional operating structure of the health plan and how each key personnel report to top-line plan management. Todd White, Chief Executive Officer (CEO) of Aetna heads our West Virginia leadership team and remains responsible for managing overall operations and resources for the Mountain Health Promise program. Our medical management functions include a Care Management Director, Social Services Director, Socially Necessary Services (SNS) Liaison, Medicaid Member Advocate, Behavioral Health Medical Director, Dental Director, and Quality Director, all of whom report to the CEO. Mr. White also supervises the plan's Community Engagement Director, Program Integrity Lead, Claims Payment Director, Information Technology Director, Provider Relations Director, Network Development Director, Member Services Director, and Chief Financial Officer, as well as our four additional key staff specific to our CAT. Kathy Szafran, Aetna's Contract Liaison/Medicaid Administrator for the Mountain Health Promise program oversees the overall delivery of the project and serves as the primary liaison with the DHHR during all phases of the Model Purchase of Service Provider Agreement.

**Figure C.1-3** illustrates how subcontractors fit into our organization and report to plan management, including lines of ultimate responsibility, key functional positions, and reporting relationships. Our Member Services Director oversees all covered and excluded medical services listed in Appendix 1-8 of the RFP as it pertains to dental, vision, and other applicable subcontracted services. Our Medical Director, Wanda Hembree, MD, has direct, daily responsibility for our radiology and pain management subcontractor, eviCore, and directs all oversight, reporting, and monitoring activities between eviCore and the health plan as well as our Joint Operating Committee (JOC). Dr. Hembree provides routine reporting of eviCore oversight directly to Todd White, our CEO. Our dental subcontractor, SKYGEN; vision subcontractor, VSP Vision Care; and SNS subcontractor, Kepro, all report to our Member Services Director, Greg Carpenter. Mr. Carpenter maintains all oversight, reporting, and monitoring activities related to their contract requirements. These subcontractors are also monitored by the JOC and Delegated Vendor Oversight Committee (DVOC). Aetna's Quality Director, Elaina Wickas, RN, BSN chairs the DVOC. The plan's JOC and DVOC meetings are attended by representatives from across

Aetna, including the Medical Director, Vendor Liaison, Chief Security Officer (CSO), CEO, Compliance Officer, Provider Relations Manager, and Member Services Director, as well as the vendor's representative; meeting minutes are reviewed, issues are discussed, and resolution to issues is tracked.

## Tools and processes used to screen available staff to fill positions

Aetna has not encountered any issues recruiting or retaining competent professionals for the Mountain Health Promise program. We were fully staffed prior to go-live in March 2020 to meet the needs of over 20,000 members Day One and we have remained fully staffed ever since, despite workforce shortages caused by the pandemic.

Aetna uses proven methodologies for completing expansion activities and maintaining ongoing operational staffing. We only hire experienced candidates who meet the qualifications and requirements of the job, and we use screening and hiring tools and techniques that define the unique knowledge, education, skills, and competencies candidates must possess for each position. The hiring process for internal staff and external candidates involves:

- Using job descriptions to clearly define and communicate to candidates the scope of work; job expectations; required knowledge, skills, competencies, and licenses/certifications; as well as to assist us in the targeted evaluation and selection of qualified finalists
- Posting positions specific to experience serving children, youth, and foster care populations and publications, websites, and other outlets such as organizations that assist those with disabilities and those that support diversity; postings are advertised on both internal and external job sites, recruiting websites, job boards, and niche sites
- Launching pipeline activities that include virtual job fairs and open houses, social sharing of job postings on LinkedIn, leadership networking, resume mining, and web sourcing
- Promoting our internal social employee referral program and using employee referral campaigns
- Reviewing candidate applications and telephonic prescreening by our specialized recruiters
- Using targeted job-specific interview guides, including behavior-based interview questions and candidate evaluation tools
- Conducting interviews of candidates by our trained hiring teams and plan leadership, including panel interviews and multi-round interviews for select positions
- Vetting key staff finalists with the State and securing State approval for key staff roles prior to extending an offer to hire
- Offering recruitment incentives to boost candidate interest (e.g., sign-on bonuses, flex scheduling, and relocation assistance)

Our hiring team is comprised of experienced subject matter experts skilled in interviewing and equipped with evidence-based tools, including competency-focused, behavior-based interview questions, to assess each candidate's ability to perform and their organizational fit. Aetna's pre-employment screening is another component of our hiring process when we hire externally. Our Human Resources department thoroughly examines each candidate's job qualifications, including education, experience, and professional references. Candidates are further examined by the supervisors and managers in their individual departments to determine if they have the required qualifications, knowledge, and experience.

Aetna is committed to the safety of our members and employees, and we conduct all state required background screening and criminal background checks on all our employees at time of hire. Our background screening process includes validation that the potential employee is not on the State

Medicaid or federal exclusion lists or was found liable for or currently facing criminal or civil action for False Claim Act violations; Medicare, Medicaid, consumer, or health care fraud; or similar findings in any jurisdiction. Aetna will not employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities.

## Process for replacing key staff and backfilling positions within timeframes

Our key staff include all personnel required in the RFP. If a key staff opening occurs, Aetna has a robust talent acquisition and talent succession process to ensure continuity and stability in the delivery of services under the contract. As part of our hiring plan, concurrent with external sourcing activities, we identify internal interim replacement staff who are subject matter experts until permanent replacement staff are hired. We use a comprehensive recruitment approach, deploying our Talent Acquisition experts immediately upon learning of a key staff opening. We place a high priority on identifying the best talent from a diverse pool of candidates throughout West Virginia to build a core team integral to the delivery system and dedicated to making a difference in our Mountain Health Promise members' lives. We only hire replacement/backfill candidates who meet the qualifications outlined in the job description. Once hired, these new employees undergo a structured orientation to their job.

Aetna will handle the notification of all key staff vacancies as defined in the RFP, in accordance with State requirements. Our West Virginia based Director of Regulatory Affairs will:

- Notify the State at least 30 calendar days in advance of any plans to change, hire, or re-assign key personnel; we understand and confirm that any key staff new hires/replacement personnel will be of equal or greater experience and qualifications than the individual they are replacing
- Employ key staff, one person per position, based in West Virginia, to be assigned to the project on a full-time basis
- Report key personnel changes to the State no later than 10 business days from learning of the intended departure
- Fill key positions within 30 business days of departure, unless the State approves a different timeline
- Remove staff the DHHR determines has interfered or could interfere with DHHR interests
- Identify a minimum staffing level and maintain that staffing level during designated business hours

## Hiring plan for Administration of the Contract

We currently have total support from 260 full-time equivalents (FTEs), reflecting the resources necessary to execute on the management of services to serve the population covered in the Mountain Health Promise program. We continuously reevaluate and revise staffing levels to ensure consistent delivery of services. It is our practice to hire and train additional staff, refine processes, provide backup resources, and institute other changes to meet the State's requirements should there be an unexpected increase in volume. For example, in 2020, we hired Jennifer Eva, our CSED Director in anticipation of the State's increased enrollment due to recent waiver expansion.

If needed, we can leverage staff from other Aetna health plans. Through the sharing of programs, policies, procedures, outcomes, and individuals with Medicaid expertise serving families, children, and youth; children and youth in foster care, adoption, and/or guardianship circumstances; aging-out youth; and individuals with special needs and disabilities, we can bring more diverse staff training and mentoring as needed. The local West Virginia leadership team is supported throughout the life of the

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contract by our national organization and will have access to the full and undiluted strength, breadth, and depth of resources available through our national Medicaid organization.

## How staffing numbers reflect adequate access

We planned our full-time employee numbers around how to meet our members' evolving needs most effectively. We recognize the complex care needs that are important for children, youth, their families, and aging-out adults, and we have included that consideration in the development of our FTE count. Over 89% of our Mountain Health Promise staff reside in West Virginia. We continuously reevaluate and revise staffing needs based on projected changes in enrollment.

| Functional Departments | Total FTEs |
|---|---|
| **Leadership and Administration** | 10 |
| **Care Management Staff** | 121 |
| **Community Engagement Staff** | 5 |
| **Systems of Care Staff** | 8 |
| **Member Services Staff** | 9 |
| **Operations Staff** | 7 |
| **Quality Management Staff** | 14 |
| **Utilization Management Staff** | 60 |
| **Medical Management Staff** | 5 |
| **Finance Staff** | 6 |
| **Appeals Staff** | 5 |
| **Provider Relations Staff** | 10 |
| **TOTAL** | 260 |

## Care management

Aetna employs 121 care management staff serving the Mountain Health Promise program, more than half of whom are care managers (a mix of RN and behavioral health specialists). Other staff include care manager coordinators, associates, managers, and supervisory managers who oversee the Care Connections Team (CCT) to serve our Mountain Health Promise membership. As the needs of the membership changes, we adjust our staffing model to address the identified treatment needs or provide additional training to our existing team to better meet members' needs. For example, we increased our CSED staff as CSED membership has grown and added additional Care Connections Team resources in the eastern panhandle where the BSS workforce is more limited in number. We also continually hire new staff as needed to meet our caseload ratio expectations.

Because we have served members in the Mountain Health Promise program and we recognize that their complex clinical needs and acuity needs can change, we have made the decision to adjust our staffing ratios, as listed below.

- Tier 1 Population Health Care Coordination: 1:350
- Tier 2 Supportive Care Management: 1:36
- Tier 3 Intensive Care Management: 1:17

These ratios enable our Care Connections Team staff to adjust their level of interactions and support based on the unique needs of each member. Appropriate staffing ratios are essential to maintaining a balanced and successful care management program. We have tailored our staffing ratio tool for caseload development to meet the needs of Mountain Health Promise membership based on quality of care reviews and workload studies that consider time elements, such as how long it takes to schedule and complete an assessment, call a member, or drive to a member's home, as well as time for case rounds with the Medical Director, community-based service collaboration, interdisciplinary care team meetings, and personal development enrichment, training, supervision, and documentation. Care Management Managers review caseload ratios and case weights (which factor in the mix/numbers of Tier 2 and Tier 3 members assigned to an individual care coordinator) monthly and any time there is a significant addition of new membership. When a Care Coordinator's caseload approaches maximum thresholds (based on maximum ratios and case weights), our leadership team conducts a staffing review. Based on the results of this review, we submit a requisition to hire additional Care Coordinators

or reallocate resources, making sure we never exceed the maximum target ratios, in a manner that enables us to provide members the services they need in an agile manner.

We assign a dedicated, local Care Coordinator to each member based on their clinical and social needs and risk factors. Care Coordinators may be Care Management Associates, Care Management Coordinators, or Nurse or Licensed Behavioral Health Clinical Care Managers, as outlined in the Support Staff table above.

## Subcontractor monitoring plan

Aetna undertakes subcontracts only when doing so adds value for our members. We use well-qualified, experienced subcontractors, when necessary, because of our confidence in the professional team we have assembled and our ability to hire locally to provide services in support of our current West Virginia Medicaid program. When we do need subcontractors with unique expertise and a proven record of accomplishments, we engage them for specific deliverables and services relative to improving outcomes for our members by providing appropriate, coordinated care and services in a financially responsible manner. Our current subcontractors have an established relationship with our internal **Network Relations Manager** and demonstrate sustained high-quality performance serving our Medicaid members, fulfilling all required quality metrics. All subcontracts are in writing and include the ability to revoke the subcontract or impose sanctions if the subcontractor's performance is inadequate. Aetna accepts financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting or working on the Mountain Health Promise program. We agree to provide a copy of our Subcontractor Monitoring Plan within ten business days of the DHHR's written request.

Our approach to managing subcontractors is successful because, in addition to our robust oversight process, we have communication strategies tailored to meet the needs of the DHHR agency and each subcontractor. Our external communication strategy allows us to distill complex requirements and volumes of data based on who is receiving the information and how they will use it. As a result, we improve outcomes by ensuring State partners and subcontractors receive information in a timely, responsive, and actionable manner. We put this communication strategy into practice by designating a single point of contact from the Aetna team, based on their expertise. These single points of contact include:

- Aetna's local **Compliance Officer** serves as the single point of contact for the DHHR regarding any subcontractor-related issues. This approach provides our state partners with a known, locally based person who knows the State's expectations and requirements. The Compliance Officer, in collaboration with Quality Management, works with the national Aetna Medicaid subcontractor management team to ensure compliance with State-specific requirements, such as contract terms and developing and monitoring performance metrics and deliverables. The Compliance Officer coordinates with the Primary Point of Contact to ensure consistent and timely communication of subcontractor information related to delivery system reform activities and current trends in delivery system reports.
- Each subcontractor has an assigned **Relationship Manager** who serves as their single point of contact. Our Relationship Managers are experts in the functions performed by the subcontractor. Our Relationship Managers provide ongoing West Virginia-specific subcontractor training, monitor performance in collaboration with our affiliates, and coordinate oversight activities. Providing a single point of contact for all subcontracts allows us and our subcontractors to reduce unnecessary duplication, leverage successful processes and programs from other markets, and support seamless

implementations of new programs. This approach also supports more robust oversight and proactive identification and more effective response to performance deficiencies.

## Subcontractor monitoring tools and activities

Prior to contracting with any subcontractor, Aetna evaluates the prospective organization's ability to perform the activities they will be expected to provide. Aetna performs a pre-delegation review audit to determine staff qualifications, clinical and administrative capabilities, integration capabilities, data transfer capabilities, operational readiness, and alignment with the project's scope of work. Our quality management program includes formal, multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care and services, and reporting provided under any subcontract. All aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements.

Our vendor management platform supports effective oversight by streamlining the collection and reporting of subcontractor performance metrics, including subcontractor scorecards used by our Vendor Management Oversight Committee, the national Delegation Oversight Committee, and Relationship Managers to monitor and analyze subcontractor performance. This approach allows us to identify increasing and potential risk of subcontractor non-compliance so we can proactively work with subcontractors to improve performance and reduce provider abrasion.

**National oversight.** At the national level, we have a centralized team of delegation oversight experts who manage the oversight process to make certain all our delegated agreements are represented and all state and contract-required elements for each plan and delegate are accounted for. This team includes members from our national Delegation Management, Quality Management, and Finance departments. The appropriate national Medical Management, Credentialing, Grievance and Appeals, and other teams conduct audits as directed by the Medicaid-specific Quality Management department. The Audit team reports audit findings to Aetna's National Vendor Delegation Oversight Committee, National Medicaid Delegation Oversight Committee, and the local health plan Delegation Oversight Committee to identify opportunities for improvement and solutions that are disseminated across our health plans.

**Financial oversight.** Aetna maintains financial oversight by assessing each subcontractor's financial condition to determine their capacity to maintain financial solvency. As part of our financial due diligence, we perform a financial review of all delegated entities at least annually to provide oversight of the contractor's continuing compliance with and ability to meet Aetna standards. Our Finance team reviews audited and unaudited financial statements such as the subcontractor's balance sheet, income statement, statements of cash flow, and interim reports. The Finance team provides an assessment of the results of operation, liquidity of current assets, and sufficiency of cash to pay claims payable and financial reserves. This detailed review assists us in determining the risk exposure to Aetna and provides a basis for calculating a letter of credit or insolvency reserve, if needed. The Finance team will make recommendations regarding increasing the frequency of additional reviews. Finally, the financial report is distributed to the plan's various oversight committees.

**Annual risk assessment.** We require each of our subcontractors to submit an annual risk assessment to us. In turn, Aetna presents an annual risk assessment to the State. To fulfill this request, each subcontractor must conduct an annual risk assessment of their fraud, waste, and abuse and program integrity procedures. Subcontractors to whom we delegate claims adjudication activities on our behalf will be subject to the same standards as Aetna's claims adjudication. This includes our vision, dental, and radiology subcontractors. All subcontractors' assessments will include a listing of their top five

vulnerable areas for that year, plus an action plan of how they will mitigate those risks. We require the risk assessment be submitted within 30 days of its completion each year.

**Privacy and security assessment.** Our Third-Party Risk Governance performs cybersecurity risk assessment to validate security controls with results and recommendations reported to Aetna's Delegation Oversight Committee. Key areas assessed include access management, asset management, communications security, cryptography, information security incident management, information security policies, operations security, personnel, and physical and environmental security.

## Sample subcontractor agreements

**Appendix A** at the end of this section are sample base subcontractor agreements in support of Aetna's Mountain Health Promise program in West Virginia. Our subcontractor agreements also include a regulatory compliance addendum (Addendum), to incorporate pertinent requirements of our contract with the Department and state law. For any proposed new subcontractors, we will provide the DHHR with the Subcontractor agreement within the timeframe required.

## Administering benefits with a benefits manager

Currently, Aetna uses four main external non-affiliated subcontractors—SKYGEN, VSP Vision Care, eviCore, and Kepro—that all contract providers to complete their own networks as part of our agreements. We employ an internal West Virginia-based Network Relations Director, Sarah White, who oversees the successful administration of all other benefits functions, including provider recruitment, member and provider calls, medical and behavioral services utilization management, reporting, and provider education, among others.

## Frequency of contact and status calls with each subcontractor

We monitor and evaluate performance metrics monthly, quarterly, and weekly depending on the subcontracted activities. As described above, our local Quality and Compliance teams collaborate with the national Delegation Oversight and Vendor Management teams to ensure performance metrics and standards align with state-specific requirements. Relations Managers meet with subcontractors weekly, monthly, or quarterly, depending on the subcontractor, to discuss the results of routine monitoring and address any areas of concern. We also hold Joint Operating Committees at least quarterly with delegated entities, executive leadership from Aetna, key leaders from functional departments, and the subcontractor's representatives. Finally, we complete a comprehensive review at least annually to measure performance efforts, including reassessment of past concerns.

The table below outlines the frequency of contact/status calls we initiate for monitoring the four main subcontractors we use for the Mountain Health Promise Program:

**Frequency of Subcontractor Contact/Status Calls**

| Subcontractor Name | Frequency of Contact/Status Calls |
|---|---|
| **VSP Vision Care** | • Monthly reporting file<br>• Monthly provider complaint and appeals file<br>• Monthly provider liaison meeting<br>• Monthly meeting either in person or telephonically<br>• Quarterly Joint Operating Committee meeting<br>• Quarterly Delegation Vendor Oversight Committee meeting<br>• SIU meeting as needed when there is a possible fraud issue |
| **SKYGEN Dental** | • Weekly meeting either in person or telephonically<br>• All MCO meetings as all the West Virginia health plans that provide Medicaid benefits use SKYGEN |

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| Subcontractor Name | Frequency of Contact/Status Calls |
|---|---|
| | • Field representative routinely meet with providers as needed to offer support with issues, concerns, and education needs<br>• Annual health plan provider forum activity, which is attended by the SKYGEN representative<br>• Monthly virtual Joint Operating Committee – with in-person meetings desired going forward<br>• Quarterly Delegation Vendor Oversight Committee meeting<br>• SIU meeting as needed when there is a possible fraud issue |
| **eviCore** | • Daily out-of-network report review<br>• Quarterly metric report of all required metrics<br>• Monthly eviCore issues log report review<br>• Quarterly Joint Operating Committee meeting<br>• Quarterly Delegation Vendor Oversight Committee meeting<br>• SIU meeting as needed when there is a possible fraud issue |
| **Kepro** | • Daily implementation update calls for the first 90 days of service (or as deemed necessary)<br>• Daily issues log (for the first six months during the transition), then monthly thereafter<br>• Quarterly metric report showing all the mutually agreed-upon metrics required of Kepro<br>• Care coordination meetings as necessary<br>• Quarterly Joint Operating Committee meeting<br>• Quarterly Delegation Vendor Oversight Committee meeting<br>• SIU meeting as needed when there is a possible fraud issue |

## Plan for a subcontractor that does not fulfill service obligations

Occasionally, despite our best efforts to avoid performance issues, a subcontractor may fail to meet the requirements of their contract. In addition to poor audit results, increases in member complaints, indications that downstream providers are not being paid, alerts from the DHHR, or news reports about a subcontractor's financial instability can trigger heightened financial monitoring, oversight activities, and quality improvement flags.

When we identify a potential deficiency, we work with the subcontractor to ensure compliance to the contract and their service obligations. Determined by the nature of the problem, remediation may include working directly with the subcontractor on customer service techniques, assisting providers in fulfilling contract service requirements, additional training, more frequent monitoring, corrective action plans, sanctions, notices to cure, or subcontractor termination.

We implement a corrective action plan to help the subcontractor become compliant and require improvement and resolution on a short timeline, typically 30 or 60 days. Our executive leaders monitor and report to Compliance and Quality on the success of corrective action plans. If a corrective action plan does not produce satisfactory results, the subcontractor's continued failure to comply may lead to deficiency notification and operational penalties as outlined in the subcontract, including monetary penalties and termination of the contract. Regardless of the reason for a subcontractor termination, we develop a transition plan and clearly communicate the change to providers and members to ensure access to services is not affected.

## Contingency plan in the event of contract termination

Although this has not happened during our contract term, Aetna has established processes to ensure all business functions, including a subcontractor contingency plan, are in place to protect our members, the DHHR, and the health plan. In the event a subcontractor must terminate a contract agreement or is terminated by us, we will follow the path outlined in their subcontractor agreement. For example, our dental provider agreement requires the subcontractor to give written notice at least 60 days prior to termination. This allows us time to research and vet a new subcontractor, maintain care standards without disruption, and help ensure continuity of care through secure transfer of member records, and

other pertinent member information. Our local leadership team would promptly inform the DHHR, members, and both the terming subcontractor and the new subcontractor, to create a seamless transition to a new subcontractor.

## Affiliated and non-affiliated subcontractors

The only subcontractor that is affiliated with Aetna is Aetna Medicaid Administrators. No other subcontractor is affiliated with us.

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## 2. Use of Department Staff

Describe the required staffing of business and technical resources the Department should provide to support the Vendor. Specifically, the Vendor should address the following:

- The nature and extent of Department support required, in terms of staff roles and percentage of time available
- Assistance from Department staff and the experience and qualification levels of required staffing for both implementation and operations phases

The Department may not be able or willing to provide the additional support the Vendor lists in this part of its proposal. Therefore, the Vendor should indicate whether its request for additional support is a requirement for its performance. If any part of the list is a requirement, the Department may reject the Vendor's proposal, if the Department is unwilling or unable to meet the requirements.

In 2020, Aetna respectfully suggested the DHHR consider creating two positions to facilitate the realization of our mutual goal of improving health and social outcomes for members receiving benefits through the Mountain Health Promise program. The DHHR fulfilled our requests, and Aetna successfully transitioned approximately 23,574 children with the help of these individuals. Tony Richards is the Director, Office of Child Welfare at the Center for Managed Care within the DHHR and Christie Fortney serves as the Bureau of Social Services District Manager/MCO Liaison.

It is through our close collaboration with the DHHR that we fully recognize the challenge workforce shortages have caused across the state. Yet, Aetna has remained fully staffed since contract award. Therefore, we do not require additional support from the DHHR currently. We do, however, recommend an additional DHHR IT staff person to help manage accessibility, privacy, and security requirements related to, but not limited to, FamilyConnect 2.0 functionality and data needs of the program and at the State level.

# Department of Health and Human Resources

## ATTACHMENT D: MANDATORY REQUIREMENTS

Instructions: The mandatory requirements must be met by the Vendor as a part of the submitted proposal. Failure on the part of the Vendor to meet any of the mandatory requirements may result in the disqualification of the proposal, at the sole discretion of the Department. The terms "must" and "shall" stipulate and identify a mandatory requirement. The Vendor is to demonstrate compliance with mandatory requirements in its proposal. If the Vendor's proposal meets the mandatory requirements, the Vendor's proposal may be included in the next part of the technical evaluation of this RFP. For mandatory requirements that necessitate a future action, the Vendor will respond in *Attachment G: Terms and Conditions* with an attestation that it will meet all mandates. For mandatory requirements involving documentation to be submitted for this bid submission, Vendors must include that documentation with its technical proposal as part of this bid submission. When appropriate, Vendors must provide narrative responses in the area below. The Vendor's narrative response for Attachment D should not exceed 50 pages.

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# Attachment D: Mandatory Requirements

**Instructions:**

The mandatory requirements must be met by the Vendor as a part of the submitted proposal. Failure on the part of the Vendor to meet any of the mandatory requirements may result in the disqualification of the proposal, at the sole discretion of the DHHR. The terms "must" and "shall" stipulate and identify a mandatory requirement. The Vendor is to demonstrate compliance with mandatory requirements in its proposal. If the Vendor's proposal meets the mandatory requirements, the Vendor's proposal may be included in the next part of the technical evaluation of this RFP. For mandatory requirements that necessitate a future action, the Vendor will respond in Attachment G: Terms and Conditions with an attestation that it will meet all mandates. For mandatory requirements involving documentation to be submitted for this bid submission, Vendors must include that documentation with its technical proposal as part of this bid submission. When appropriate, Vendors must provide narrative responses in the area below. The Vendor's narrative response for Attachment D should not exceed 50 pages.

The completed **"Attachment D – Mandatory Requirements"** can be found at the end of this section.

## Compliance with all applicable requirements [MR001]

**The Vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, state or federal laws and regulations, waiver amendments, or State Plan amendments.**

Aetna Better Health® of West Virginia (Aetna) will comply with all applicable requirements outlined in this procurement, the Service Provider Agreement, and any modifications pursuant to changes in State policy, State or federal laws and regulations, waiver amendments, or State Plan amendments. We have designed our practices and processes to maintain compliance with all applicable requirements, including timely implementation of changes. **In the last 8 years our EQRO audit scores for the Mountain Health Trust and Mountain Health Promise programs were 100% compliant for 7 of the last 8 years.**

As required in RFP Appendix 2, Todd White, our Chief Executive Officer (CEO) is ultimately responsible for ensuring compliance with all contract requirements. Todd is supported by our Director of Regulatory Affairs, Alva "Fuzzy" Page III, Esq. and our Program Integrity Lead Tanya Cyrus. Fuzzy also maintains a direct line of report to the board of directors and is responsible for continually monitoring policy, regulatory, and legislative changes to maintain compliance with applicable requirements. When we identify changes, Fuzzy and Tanya work with the applicable departments to ensure timely implementation of changes.

### Regulatory Compliance and Oversight Committees

Our formal oversight committee structure, depicted in **Figure D-1** helps to ensure our compliance with all contractual and regulatory requirements. The committee members integrate Aetna Medicaid's medical functions, operations departments, network, and members into the quality management and compliance programs through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements.

To ensure appropriate levels of compliance oversight, Aetna has multiple levels of oversight. Tanya, our Program Integrity Lead, oversees the Regulatory Compliance Committee, which is comprised of representatives from senior executive leadership and the following departments: Medical Management, Quality, Health Services, Provider Services, Member Services, special investigations unit, Operations, Grievances and Appeals, Pharmacy, Provider Network, and Long-Term Care. The Compliance Officer collaborates following state and federal law.

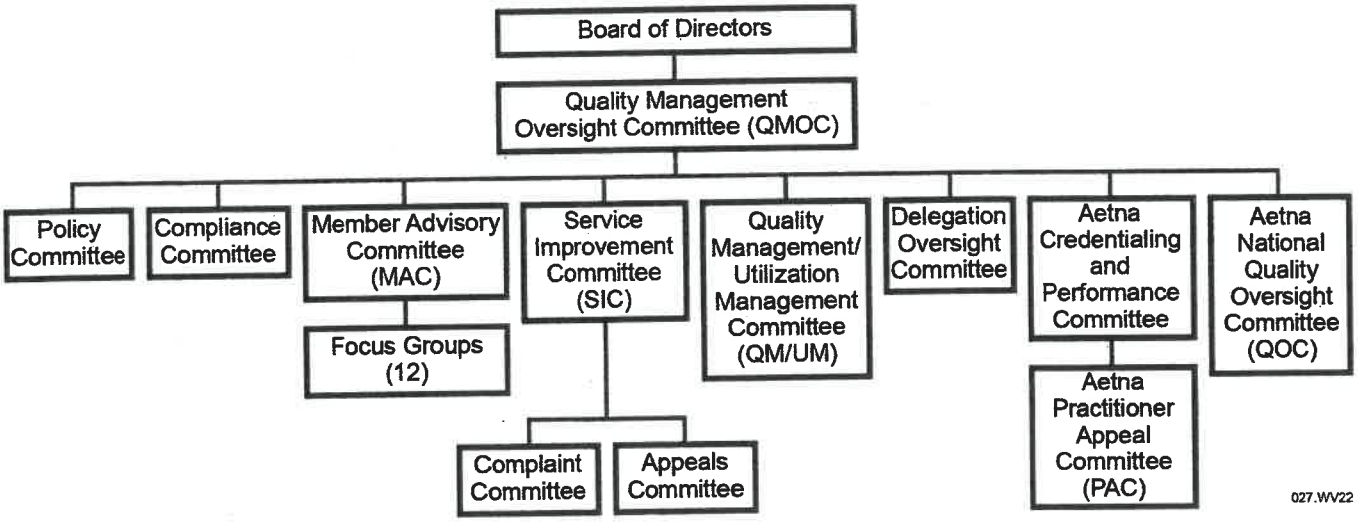


***Figure D-1:*** *Aetna's comprehensive quality and compliance committee structure directs organization wide oversight to support ongoing compliance with contractual and regulatory requirements.*

Our Compliance Committee meets quarterly, at a minimum. The Compliance Committee's major responsibilities include reviewing and monitoring external controls and metrics such as compliance issues involving fraud, waste, and abuse; external quality review oversight activities and audits; regulatory and contractual compliance; and corrective action plans. The committee identifies potential compliance gaps and reports any instances of non-compliance to the Quality Management Oversight Committee monthly. The Compliance Officer also provides an annual compliance report to the Board of Directors.

We also maintain a Regulatory Compliance Committee on the Board of Directors. This committee is charged with oversight of compliance activities to ensure contractual requirements as well as state and federal regulations are met. They review audit findings and other compliance efforts and report to the Board of Directors. This committee is comprised of the health plan CEO, Chief Financial Officer, and two appointed board members. The Compliance Officer serves on the committee but will not have voting rights.

### Effective system for promptly responding to compliance issues

We maintain an effective system to ensure prompt response to compliance issues, including investigation of potential compliance issues, correction of identified problems, and coordination with other agencies as appropriate. Our policies and procedures outline a process for developing effective corrective action plans (CAPs), including root cause analysis, and addressing specific compliance concerns. Our plan compliance officer, CEO, and appropriate operational leadership review and sign CAPs. Our subcontractor and downstream subcontractor agreements include terms, as relevant, to support enforcements of CAPs when they aren't met, including financial sanctions, payment withholds and liquidated damages.

## Accepting State established rates [MR002]

The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services.

Aetna will continue to accept the rate established by the State on a per member per month basis for managed care physical health and behavioral health services, and we understand the normal rate setting process that will occur for each subsequent year of the contract.

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## Timely operationalization of all requirements [MR003]

**The Vendor must have all requirements operational, as agreed upon with the Department, by July 1, 2023.**

When implementing the initial Mountain Health Promise program, **we achieved nearly 95% readiness within 4 months, exceeding the 75% implementation requirement.** As an established plan, Aetna is positioned to ensure full compliance by July 1, 2023. Our process for ensuring we have all requirements operational for the new contract will include the following activities:

- Completing a detailed and comprehensive analysis of requirements under our current contract with the new contract requirements to identify any changes
- Developing a work plan that addresses all activities, work streams, and variables to support updating our policies, process, and practices to operationalize such changes
- Utilizing a project management governance structure to align implementation elements and project staff, providing clear lines of oversight, monitoring, and accountability




This approach makes certain we meet all operational requirements for a contract go-live.

## Compliance with West Virginia Code §9-5-27 [MR004]

**The Vendor must comply with W.Va. Code §9-5-27 requirements, including, but not limited to, reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80% of the full-time equivalent positions are located.**

Aetna complies with West Virginia Code §9-5-27 requirements, including, but not limited to, reporting; maintaining voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where we currently have nearly 90% of the full-time equivalent positions are located.

### Reporting

We meet all monthly, quarterly, and annual reporting, including those identified in Appendix D of the Service Provider Agreement. As part of our reporting, we provide annual reports to the State of West Virginia, Department of Health and Human Resources (DHHR) as outlined in West Virginia Code §9-5-27 including:

- Number of claims submitted, approved, denied, and appealed
- Resolution of appealed claims
- Average time of an appeal
- Average length of stay in a child residential care center
- Health outcomes

Based on our prior experience helping to develop reports for the Legislative Oversight Commission on Health and Human Resources Accountability and the Foster Care Ombudsman, we understand the importance of working closes with Bureau for Medical Services (BMS) and its other vendors to ensure the data is accurate and presented in a fully transparent manner. We work with BMS to provide ongoing reporting necessary to complete the final Legislative Oversight Commission on Health and Human Resources Accountability and the Foster Care Ombudsman that is due by July 1, 2023.

## Advisory group

Aetna has established voluntary advisory groups, as required by West Virginia Code §9-5-27, to ensure stakeholders had, and continue to have, a voice in the program development process. Due to the COVID Public Health Emergency, which began shortly after the contract start date, we quickly undertook the steps necessary to hold the advisory groups virtually, to provide a safe and accessible forum for the advisory group members. We have held 48 focus groups including:

- 8 Member Advisory Councils, with foster parents, kinship caregivers, adoption, and biological parents
- 17 socially necessary services (SNS) focus groups
- 14 residential treatment facility focus groups
- 9 grand families focus groups.




To facilitate input from other key stakeholders, we have also held 9 Mountain Health Promise Governance Council meetings.

We have submitted quarterly summaries to the State of the recommendations from these focus groups and the steps we've taken to address the recommendations. A few examples of the impact of these focus groups include:

- Increased training for all child welfare stakeholders to reduce the use of out of home care
- Reviewed practices to better support individuals seeking assistance without fear of repercussion
- Continued focus on collaboration between the various areas of the child welfare system
- Developed quality services to support children and families within their communities
- Provided additional information to caregivers about child welfare and the resources available.

These voluntary advisory groups have been critical to ensuring the program had developed and continues to evolve in a manner that effectively responds to a wide range of member, family, state agency, and other stakeholder needs.

## 80% staffing requirement

**Today close to 90% of Mountain Health Promise staff live in West Virginia.** The kids and families served by the Mountain Health Promise program are our neighbors, and as fellow West Virginians, we are committed to helping them improve their health and wellbeing. We will continue to exceed the 80% full time equivalent threshold through the contract term, as we have throughout our 26 years as a West Virginia MCO.

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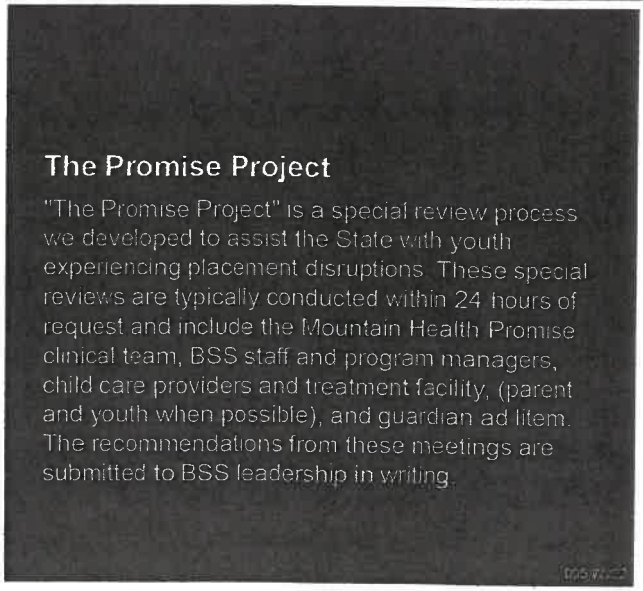
## Adherence to Department caseworker decisions [MR005]

**The Vendor must adhere to the case management decisions of the Department caseworker, multidisciplinary team (MDT), or court, but must document and provide all recommendations for case management, as appropriate.**

Aetna adheres to all case management decisions of the DHHR caseworker, multi-disciplinary team, or the court. **We have attended over 6,300 multi-disciplinary teams and health plan inter-disciplinary care team meetings since April 2020, including 447 psychiatric residential treatment facility meetings.** Our processes include documenting and providing all recommendations for case management, as appropriate. We regularly work DHHR caseworkers, the judicial system, and other stakeholders involved with our Children and Youth Projects to identify and address the needs of members.




Our care managers are trained to document all decisions, recommendations, and relevant information in Dynamo, our case management system. This documentation includes information related to the Medicaid plan of care and the case management documents of the State, courts, and/or families, as appropriate. DHHR case workers may access information, including such recommendations, via our FamilyConnect system. We also document and provide all recommendations for case management, as appropriate, fulfilling our commitment to coordinate with DHHR caseworkers and incorporate their case plan recommendations into our integrated care plan when we work with the inter-disciplinary team to create it.

Through the State-led multidisciplinary teams and health plan-initiated inter-disciplinary care team meetings, we collaborate with the member's case worker, DHHR, Child Protective Services (CPS), Aetna's Care Coordination team, physical health, behavioral health, and Socially Necessary Services (SNS) providers, child's guardian, kinship, adoptive, or foster parents (if appropriate), court system, and others. Further, we know that many of the children and youth have been exposed to Adverse Childhood Experiences (ACEs), resulting in early toxic stress and trauma. We effectively coordinate care through intensive, trauma-informed, and specialized care coordination to help address complex needs including toxic stress and trauma within the Mountain Health Promise members. Our justice system of care administrator assists with communication and coordination with judicial systems, making certain that the multi-disciplinary team and the member's circle of support are engaged throughout the case management process.

## Qualified residential treatment program placements [MR006]

**The Vendor must comply with requirements for qualified residential treatment program (QRTP) placements as described in the Service Provider Agreement (SPA).**

We understand the challenges the State has had implementing QRTP services and are working with DHHR to implement residential mental health treatment facilities (RMHTFs) and the Pathway Assessment process to support the continuum of care for children and the families in need of

behavioral health services. Aetna is prepared to support the state in implementing RMHTFs to provide a high level of mental and behavioral health services for children with serious emotional or behavioral disorders or disturbances with severe and persistent challenges in social, emotional, behavioral, and/or psychiatric functioning who have been:

- Referred to the pathway to children's mental health services
- Assessed by a qualified independent assessor
- Recommended for short-term residential services.

We support the goal of this service is to provide mental health intervention services in a residential treatment setting to stabilize the child so they can be served in a community family setting. Our leadership team have already been working with the State as a member of the "R3" task team to develop this model of care.

We will meet and comply with requirements for qualified residential treatment programs as described in Section 13.2 of the Service Provider Agreement, if or when these services become available. We will also comply with the standards and regulations of children and youth being placed in a QRTP as defined by the Family First Prevention Services Act federal and state legislation. To address ACEs and childhood trauma experienced by members, we are committed to providing our trauma-informed treatment model and meeting the 30-day assessment requirement. We will also comply with accreditation requirements and clinical staffing expectations.

In addition, we will work with the QRTP to:

- Support safe family contact while youth are in their programs
- Actively participate in transition planning (upon admission) for members who are placed in their programs
- Assign a care manager to each child who participates in treatment team meetings, making certain that the facility has completed necessary evaluations.

**Our approach to coordinating care with community stakeholders has enhanced our ability to ensure children and youth are served in the least restrictive setting.** For example, we are using the Child and Adolescent Functional Assessment Scale (CAFAS) tool for all youth in shelter care and residing at in-state residential facilities to evaluate their functioning and help ensure placement in the correct level of care. If the CAFAS indicates a child is not in the appropriate level of care, the care team immediately initiates efforts to transition the individual to the correct level of care. We share our data, including identified barriers, with the Bureau for Social Supports (BSS) and conduct join monthly reviews of youth with CAFAS scores indicating they can be served in the community. These youth are referred to one of our case managers who reaches out to the facility and the BSS worker to assess progress in treatment and discharge planning and to address barriers that are keeping the youth in the facility. We work to transition these youth into community and family environments through use of Family Finding and our foster care provider review process. **We have collaboratively worked with BSS and providers to reduce the number of youths in group residential treatment facilities from 821 in May 2022 to 662 as of October 2022, which is below the DOJ goal of 689 by December 31, 2022.**

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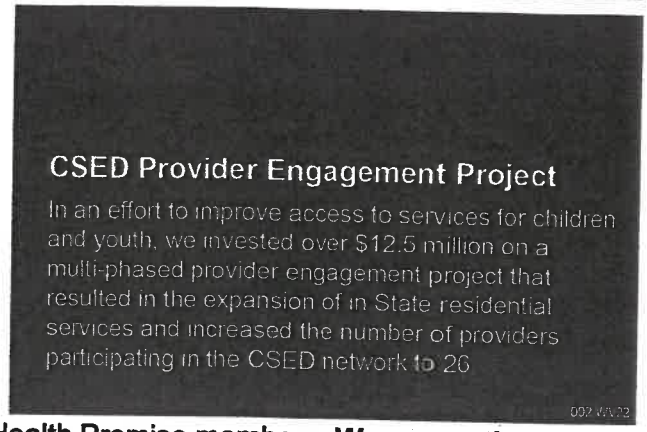
## Physical health and behavioral health provider network [MR007]

**The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA) and serves all counties in the State.**

Aetna maintains a physical health and behavioral health provider network that provides adequate access and serves all counties in the state as required by Appendix K in the Service Provider Agreement. **DHHR has approved our contracted provider network annual report demonstrating that we meet adequate accessibility standards throughout our administration of the Mountain Health Promise program.** We maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services are available, and in a timely manner to the Mountain Health Promise members. **We currently contract with over 14,400 providers, which includes over 3,000 Primary Care Physicians, including over 500 pediatricians, and 1,071 behavioral health specialists.** To increase access to services for members with limited transportation, we offer regular and specialty services virtually. In **2021, members aged 5 to 19 received over 48,000 telehealth services.** We ensure access to all services included in the managed care organization (MCO) benefits package, even where a standard for the specialty type hasn't been defined.




As required by Appendix K of the Service Provider Agreement, for all pediatric populations served, we **contract with a sufficient number of active providers to meet the standard of one PCP for every 250 members per county.** We actively recruit and maintain a robust network, including pediatric and youth-focused behavioral health and pediatric specialists to effectively serve children and youth members. We regularly evaluate the diversity of our provider network, to support member choice in selecting providers that meet each member's cultural, religious, gender, linguistic and other needs and preferences. For children who have aged out of foster and adoption assistance eligibility, we recruit and maintain obstetricians/gynecologists' participation to adequately serve those individuals as well.

We adhere to the Medical Provider Network Time and Travel Distance requirements for each specialty group as outlined in the Service Provider Agreement Appendix K.

## NCQA accreditation [MR008]

**The Vendor must be accredited by the National Committee for Quality Assurance (NCQA).**

**Aetna achieved a 4-Star rating on our recent NCQA reaccreditation review, making us the only 4-Star Medicaid plan in West Virginia.** We also maintained our Electronic Clinical Data Distinction. Based on Aetna Medicaid's 's 32- year history of NCQA accreditation, we are confident in our ability to maintain accreditation at the highest level throughout the term of this contract.

We are in the process of obtaining NCQA Health Equity accreditation and are working closely with DHHR to implement necessary changes in support of achieving NCQA Health Equity requirements. Four of our affiliate Medicaid plans have NCQA distinction in Multicultural Health Care. **Our affiliate plan in Michigan was selected to participate in NCQA's Health Equity Accreditation Plus Pilot**

**and is a Health Equity Plus accredited plan.** This national experience is one example of our understanding and early adoption of the NCQA Health Equity Plus standards.

## Requested supporting documentation [MR009]

The Vendor must provide all requested supporting documentation upon notification of award, or a later date as specified by the Department, according to the requirements described in Appendix 5: List of Requested Documents.

As the current MCO, Aetna has developed all the required documents described in Appendix 5 of the RFP. As detailed in the following table, we routinely submit many of these documents, such as the vendor ownership and control, fraud, and abuse compliance plan, or have included them in our response to this RFP. We are prepared to submit current versions of all the documents upon notification of award, or later as specified by DHHR.

| Document Description | Current Document Status | Ready for Submission |
|---|---|---|
| Vendor and subcontractor organizational charts | Submitted annually to DHHR and included in our response to Attachment C | ✓ |
| Hiring Plan | Staff already onboard | ✓ |
| Certificate of Authority from the Office of the Insurance Commissioner and a copy of all materials submitted to the West Virginia insurance commissioner | Submitted annually to DHHR and a copy of our Certificate of Authority is included in response to Attachment B Section 2, Mandatory Qualifications | ✓ |
| Vendor ownership and control disclosures | Submitted annually to DHHR | ✓ |
| Standard provider contracts and disclosure forms for PCPs and specialists (including dentists, behavioral health providers, and hospitals) | Currently approved by DHHR | ✓ |
| A copy of the contract if any aspect of claims processing, such as data entry, is contracted out | N/A-we do not contract out claims processing | ✓ |
| Fraud and abuse compliance plan | Currently approved by DHHR-Annual | ✓ |
| Employee false claims training | Provided to staff at hire and annually | ✓ |
| Advance directive policies and procedures, including procedures for informing members of their right to make advance directives, providing physicians and members with appropriate forms of guidance, and ensuring that advance directives are maintained in members' medical records | Currently approved by DHHR | ✓ |
| Vendor/other benefit manager grievance and appeals policies and procedures | Currently approved by DHHR | ✓ |
| Physical health and behavioral health provider recruitment plan | Currently approved by DHHR | ✓ |
| Vendor/other benefit manager credentialing policies and procedures | Currently approved by DHHR | ✓ |
| Sample explanation of benefits (EOB) forms | Currently approved by DHHR | ✓ |
| Member/Provider Services department toll-free contact phone numbers | Established and published as required, including in Provider Manual and Member Handbook | ✓ |
| Phone call transfer protocols and decisions trees | Currently approved by DHHR | ✓ |
| Disenrollment policies | Currently approved by DHHR | ✓ |
| Policy on prohibitions of inappropriate physician incentives | Currently approved by DHHR | ✓ |
| Vendor policies on reimbursement for crisis stabilization services | Currently approved by DHHR | ✓ |

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| Document Description | Current Document Status | Ready for Submission |
|---|---|---|
| Medical prior authorization policies, procedures, and flowcharts | Currently approved by DHHR | ✓ |
| Sample clinically appropriate treatment plan (care plan) that addresses the coordination of primary, specialty, ancillary, community, and social support and carved-out services for members identified as having special health care needs | Currently approved by DHHR | ✓ |
| Quality improvement plan that includes plans to evaluate how effectively the plan is delivering quality and accessible services that address the needs of and areas of improvement for children with special needs | Submitted annually to DHHR | ✓ |
| Medicaid and commercial HEDIS reports from the past two years | Medicaid HEDIS reports are submitted annually, commercial HEDIS reports are available upon request | ✓ |
| Policies and procedures for authorizing SNS | Currently approved by DHHR | ✓ |
| A copy of the plan's health risk assessment form or protocol, whether to be performed by the plan or a subcontractor | Currently approved by DHHR | ✓ |

## Evidence of efforts to contract with enrolled providers [MR010]

The Vendor must provide evidence of efforts to contract with all currently enrolled providers under the DHHR's fee-for-service (FFS) Medicaid program.

As a West Virginia MCO for more than 26 years, Aetna understands and has processes in place to provide evidence of our efforts to contract with all enrolled providers under DHHR's FFS Medicaid program. We use the DHHR's PROV12 monthly report to identify FFS enrolled providers who may not be in our network. When we identify a FFS Medicaid enrolled provider who is not in our network, we outreach and attempt to contract with them.

In addition, when we identify providers who are providing services to Medicaid members or would like to join our Medicaid network, such as out of state providers or in state Children with Serious Emotional Disorders (CSED) providers, we assist them in enrolling with DHHR Medicaid, so they can participate in our network. **Since March of 2020, our efforts to work with providers to enroll as CSED providers has resulted in doubling the number of enrolled CSED providers.**

## Credentialing and re-credentialing [MR011]

The Vendor must credential and re-credential new physical health and behavioral health providers in accordance with federal and State requirements, as defined by the DHHR.

Aetna credentials and re-credentials new physical health and behavioral health providers in accordance with federal and State requirements, as defined by DHHR. **In 2021, we credentialed or recredentialed 750 individual providers and 232 facilities for Aetna participation.** As part of our ongoing quality improvement processes, our Credentialing Performance Committee solicits feedback on our credentialing and re-credentialing processes on an ongoing basis. They review provider complaints, feedback, and trending analyses to drive ongoing improvement in our policies, procedures, systems, and processes. We receive practitioner advice with respect to criteria for credentialing and re-credentialing of individual health care professionals. **In our 2021 provider satisfaction survey, 85% of respondents expressed overall satisfaction with Aetna.**

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## Credentialing

Individual providers who are members of a contracting group, such as an independent association or medical group, are credentialed individually. We understand DHHR will provide this information to us to make quality determinations through our Credentialing Performance Committee. **From January through July of 2022, we credentialed 127 new providers with an average turnaround time of 17.77 days, significantly faster than the state requirement of 45 days.**

We adhere to specific credentialing requirements found in the Service Provider Agreement Section 3.1.6.1 related to PCPs, and obstetrician and gynecologists as the process must include a visit to the provider's office, documenting a structured review of the site and medical recordkeeping practices to ensure conformance with the MCO standards. Related to behavioral health providers, we adhere to requirements found in Service Provider Agreement Section 3.1.6.3 to verify the following:

- Verify that comprehensive behavioral health centers or licensed behavioral health centers hold a valid license through the West Virginia Office of Health Facility Licensure and Certification
- Verify that an independent psychologist or an independent practicing licensed social worker holds current license with their professional boards
- Verify that a physician is approved to provide Suboxone® treatment by DHHR. A licensed MCO physician who intends to provide Suboxone treatment must meet established requirements.

For individual practitioners, we consider the information provided through DHHR's completed credentialing and verified information packet. Our credentialing process uses intelligent process automation to improve the efficiency with which we collect and enter accreditation data into our provider data staging tool. This supports greater accuracy, timely updating of credentialing information, and eliminates defects on credentialing applications submitted to our credentialing verification organization.

We comply with West Virginia C.S.R. §114-53-6 and 42 C.F.R. 455, Subpart B and at a minimum include a statement by the applicant regarding the following:

- Physical or mental health problems that may affect current ability to provide health care
- History of chemical dependency/SUD
- History of loss of license
- Conviction of a Felony as required by West Virginia C.S.R. §114-53-6.3 and other criminal convictions as required by 42 C.F.R. 455.106
- History of loss or limitation of privileges or disciplinary activity
- History of debarment, suspension, or exclusion from any federal or State health care programs
- Correctness/completeness of the application attestation.

During the initial credentialing process, we verify the following:

- Identity and the exclusion status of the provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of federal databases as described in 42 C.F.R. 455.436
- Verify the provider holds a current valid license to practice
- Validate the provider holds a Drug Enforcement Administration (DEA) or Controlled Dangerous Substance certificate, as applicable
- Verify graduation from medical school and completion of a residency, or other post-graduate training, as applicable

- Verify board certification or eligibility, or specialized training as appropriate
- Inclusion of work history
- Identify any professional liability claims history
- Ensure good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility (this requirement may be waived for practices that don't have or don't need access to hospitals)
- Verify the provider holds current, adequate malpractice insurance with minimum coverage requirements of $1 million per individual episode and $1 million in the aggregate
- Identify any revocation or suspension of a state license or DEA/ Bureau of Narcotics and Dangerous Drugs number
- Identify any curtailment or suspension of medical staff privileges (other than for incomplete records)
- Identify any censure by the state or county medical association
- Identify any member complaints

Our review also determines that practitioners have office hours and wait times that meet our West Virginia contract standards, or the medical director or designee approves exceptions as needed to allow for appropriate network configuration.

### Re-credentialing

The process for re-credentialing will follow the same process and policy as previously described for initial credentialing. Our standard process is to re-credential every three years. In between formal credentialing cycles, we monitor the following as part of our ongoing quality review:

- For individual practitioners: State board sanctions; loss of license; Office of Personnel Management/Office of Inspector General exclusion reports; Medicare opt-out; member complaints that are tracked and monitored through our Provider Relations department's monitoring; our grievance and appeals process, as well as received through our quality processes; and internally identified potential quality-of-care concerns tracked through our extensive monitoring and quality management tools and processes
- For non-individual providers: Office of Personnel Management/Office of Inspector General exclusion reports and potential quality-of-care concerns identified through our extensive monitoring and quality management tools and processes.

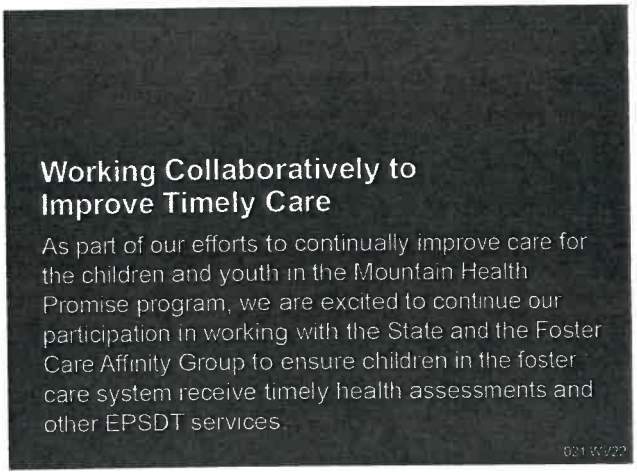
As part of our ongoing quality improvement processes, our Credentialing Performance Committee solicits feedback on our credentialing and re-credentialing processes on an ongoing basis. They review provider grievances, complaints, feedback, and trending analyses as available to make recommendations on revising and improving our policies, procedures, systems, and processes.

## Early and periodic screening, diagnosis, and treatment [MR012]

The Vendor must ensure compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requirements for applicable members, as outlined in the Service Provider Agreement (SPA).

Aetna complies with EPSDT program requirements for Mountain Health Promise members, as outlined in the Service Provider Agreement. Since 1996, we have been making certain children and adolescents participating in West Virginia Medicaid children receive eligible EPSDT services including comprehensive preventive, dental, behavioral health, and developmental and specialty services for a

healthier West Virginia. We believe early detection, screening, and interventions are essential to identifying developmental, physical, and behavioral issues. We recognize that PCPs are central to the identification of possible developmental delays in young children as part of the EPSDT program. We offer families a choice of providers who conduct ongoing developmental surveillance in accordance with medical necessity criteria specific to EPSDT.




To make sure all eligible members have access to HealthCheck services, we provide a combination of written and oral notification methods designed to effectively inform all EPSDT-eligible individuals, their families, their foster care parents, and CPS worker, if applicable, about the EPSDT program. We will continue to provide appointment reminders, follow-ups, and outreach to EPSDT-eligible members, including targeted education and post card reminders for needed screenings. demonstrates the success of our EPSDT initiatives.

Aetna care managers also educate members 21 years and under about EPSDT during outreach calls. If we identify a gap in care through our documentation system, we address it on a call with the member or guardian. We cover all EPSDT services. If a service not currently covered by Aetna is considered EPSDT, we make an exception and pay for the service. We don't prior authorize covered periodic screenings and immunizations.

We work closely with providers to make sure all Medicaid-eligible members under the age of 21 receive EPSDT services and their parents, caregivers, and providers use resources effectively. Aetna routinely monitor for gaps in care using internally using our care management and utilization management systems. We provide EPSDT coverage that aligns with guidelines outlined in the Service Provider Agreement, including providing an initial health assessment and comprehensive exam within 30 calendar days of placement in foster care. If necessary, we also provide a follow-up visit within 90 calendar days of placement in foster care. Once the child is enrolled with Aetna, we work with the assigned BSS worker to make sure these important health assessments, exams, and follow-up visits are performed timely.

## Post-stabilization care [MR013]

**The Vendor must comply with post-stabilization care per applicable federal and State requirements, as defined by the Department.**

Aetna will continue to comply with post-stabilization care per applicable federal and state requirements, as defined by DHHR to maintain, improve, or resolve the member's stabilized condition in compliance with 42C.F.R. 438.114 and 42 C.F.R. 422.113(c). Our approach to post-stabilization care promotes efficient and timely coordination of appropriate care of a managed care member after the member's condition has been determined to be stable. Our efforts include discharge planning and arrangement of continuing care services to support continued improvement and engagement with the multi-disciplinary team to ensure the best quality member outcomes via the most appropriate level of care. We make timely and reasonable payment on behalf of members for services obtained from a provider or supplier whether that provider or supplier contracts with Aetna to provide covered services. **We pre-approve post-stabilization care services within one hour of receiving a request.**

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## 24-hour access to a provider or service in emergency situations [MR014]

The Vendor must provide 24-hour access to a provider or service in emergency situations.

Aetna provides members with 24/7/365 access to a provider or service (including medical, behavioral, dental, and crisis stabilization) in emergency situations through a variety of resources. We maintain a very robust provider network with nearly all the emergent care providers in the West Virginia territory. We also provide 24-hour behavioral health and nurse education lines with daytime live responders and 24/7/365 resources, which are available to all Mountain Health Promise members including those served under the CSED waiver. We do not require an authorization for emergent services, to ensure there are no administrative barriers to seeking or receiving needed care.

Our goal is for each Mountain Health Promise member to be associated with a medical home that arranges for after-hour services. Our medical home model delivers primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to every child and adolescent. Medical homes address preventive, acute, and chronic care from birth through transition to adulthood and aid facilitation of our integrated care coordination with a multi-disciplinary team of members and families, PCPs, specialists and subspecialists, hospitals and health care facilities, public health, and the community. We have value-based arrangements with several medical homes that offer after-hours services to encourage and increase value within their contract.

We have continuously worked to enhance access to emergency services through such activities as:

- Providing access to mobile crises services via providers in four regions of the state
- Expanding the CSED provider network through our investment of over $12.5 million to implement a multi-phased provider engagement project
- Maintaining a list of emergency shelters within the state

We also use a variety of mechanisms to educate members on the range of after-hours resources that are available, including urgent care services. We understand that members may need additional supports and education and use member advocates to assist members in navigating the health care system and understanding the ranges of services provided and how to access emergency services.

## Access to the full range of specialty and facility service providers [MR015]

The Vendor must, based on Department provider access to care requirements, ensure access to the full range of specialty and facility service providers for members in applicable populations with complex needs.

Aetna complies with DHHR's provider access to care requirements and provides access to the full range of specialty and facility service providers for members in applicable populations with complex needs. Our strong community relationships, integrated network analysis and recruitment processes, and high-touch model of network management assist us in providing a network sufficient to meet the needs of the Mountain Health Promise members. Through our network management strategies and processes, we continue to provide timely access to culturally competent primary and specialty care services necessary to promote DHHR's goals. We work with our provider partners to expand specialized services as needed. Our provider network, which meets DHHR's expectations and requirements, includes all provider types for the highest quality of care, including the following:

- **PCPs**: 3,000+
- **Specialty physicians**: 8,640

- **Behavioral health providers**: 1,071
- **FQHCs**: 352 (includes school-based providers, representing the total number in West Virginia)
- **CSED providers**: 26 (represents the total number in West Virginia)
- **Rural health clinics**: 72 (represents the total number in West Virginia)
- **Acute and behavioral health care hospitals**: 81 (includes in-state and out of state)
- **Children's hospitals**: 3 (represents the total number in West Virginia)
- **Psychiatric residential treatment facilities**: 3 (represents the total number in West Virginia)
- **Group home providers**: 34 (represents the total number in West Virginia)

We are currently working with BSS and two Drug Free Moms and Babies Project sites and continue efforts to contract with all Drug Free Moms and Babies sites in West Virginia. This program provides early intervention to mothers and babies affected by SUD.

## Ensuring receipt of primary care services [MR016]

The Vendor must ensure that individuals in applicable populations who have specialists as primary care providers (PCPs) are receiving primary care services on an ongoing basis.

Aetna designates physicians outside the specialties of general or family practice and pediatricians as PCPs for specific individuals including persons with disabilities. This approach helps provide access to the care needed for the children and youth populations within the Mountain Health Promise program whose underlying health conditions are best managed by specialists. We have designed our process and procedures to make sure individuals in applicable populations who have specialists as PCPs are receiving primary care services on an ongoing basis. In the event a member elects to have a specialist serve as his or her PCP, our care managers reach out to the specialist to participate in care planning. If the specialist is new to performing the functions of a PCP, we educate them on the requirements of being a PCP and monitor them through gaps-in-care reports for relevant HEDIS® measures and member feedback on appointment access or practitioner behavior. We provide ongoing support and use the same interventions as we would use for non-specialist PCPs to address opportunities for improvements.

For providers (both PCPs and specialists who function as PCPs) who show low compliance rates, the QM team reviews a sample of records for additional investigation. This assessment of outcomes becomes a part of the quality plan, and both the UM and QM teams review outcomes with the providers and CM team. We also encourage providers to perform well visits in tandem with acute visits to record preventive services through coding. We emphasize that providers can either address EPSDT requirements while the member is in the office or schedule additional follow-up for an EPSDT visit.

## Monitoring PCP panels for compliance [MR017]

The Vendor must monitor primary care provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) limit of Medicaid members assigned per PCP, for applicable populations.

Aetna is committed to making sure members receive timely access to necessary services, and the importance of maintaining compliance with PCP panels to support such access. **We are the only West Virginia health plan to receive a perfect NCQA rating of 5 for three years in a row related to members experience getting needed care and getting needed care quickly.** We have established policies and procedures to support ongoing monitoring PCP panels for compliance the Service Provider

Agreement Section 3, including the BMS limit of 2,000 Medicaid members assigned per PCP, for applicable populations.

Access to care by pediatric and youth care physicians is particularly important, we believe, and essential to counteracting trauma, helping to create resiliency, and improving the health of our children and youth members. We currently have 100 percent of members with access to a PCP within the time and distance standards. We have 99 percent coverage across West Virginia. **We currently contract with over 3,000 PCPs, including over 500 pediatricians, and over 97% of PCP network has open and accessible panels for new members.**

As a part of our PCP panel management and monitoring activities we do the following:

- Provide monthly reports of current assigned members, no later than five business days after the end of each month unless the PCP has agreed to an alternate schedule. PCPs can also access this report through our secure provider portal
- Monitor claims and service utilization data and inform our network development and provider recruitment teams to identify potential needs. If we identify gaps, or potential gaps, we proactively work to expand the network and ensure ongoing timely member access to PCPs services
- Review quarterly analysis and trending of member grievances to identify potential availability or accessibility issues, perform root-cause analysis
- Use data on single-case agreements and our annual out-of-network report to identify providers for recruitment into our network
- Have processes that address PCP ratios in circumstances involving PCP teams, such as teaching facilities where residents and physicians' assistants serve as a PCP, under the supervision of an attending physician.

If we identify, or receive notification that DHHR has identified, a PCP total Medicaid member caseload exceeds the 2,000 Medicaid member limit, we analyze the assigned membership and either reduce the caseload for the PCP or seek an exception. Aetna works with the PCP and DHHR to obtain consent for any exceptions, and will request for exceptions as required by DHHR, including the following:

- Continuation of established care
- Assignment of a family unit
- Availability of mid-level clinicians in the practice that effectively expand the capacity of the physician
- Inadequate numbers of providers in the geographic area.

## Network standards documentation and geographic mapping [MR018]

The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).

Aetna submits network standards documentation and geographic mapping reports in accord with the reporting instructions within the Service Provider Agreement. **Over the last three years, DHHR has approved our annual network standards documentation, including geographic mapping reports.** Our network standards documentation is submitted in accordance with our contract reporting instructions demonstrating that our network meets physical, behavioral, and specialists needs. Example excerpts of our 2021 report is shown below in **Figure D-2**. We will follow this same process in accordance with the project contract requirements and specifications. Through this documentation and geographic mapping process, we may identify opportunities to enhance our existing network. We

**currently contract with over 14,400 providers, which includes over 3,000 PCPs, including over 500 pediatricians, 8,640 specialty physicians, 1,071 behavioral health specialists, and 81 physical health hospitals** including adjacent border states.

**WV Department of Health and Human Resources**
**Bureau for Medical Services**
**Mountain Health Trust**
**Network Submission and Network Adequacy Evaluation**
**CY2021**
**Aetna Better Health of West Virginia**
**Provider-to-Enrollee Ratios**

**Instructions**
Fill in the highlighted cells only.

| County Information | | | Primary Care Provider (PCP) | | | | OB/GYN Provider | |
|---|---|---|---|---|---|---|---|---|
| County Code | County Name | Region | Required Number of PCPs to Meet ADULT Standard | Number of PCPs Contracted for ADULT Standard | Required Number of PCPs to Meet PEDIATRIC Standard | Number of PCPs Contracted for PEDIATRIC Standard | Required Number of OB/GYNs to Meet Standard | Number of OB/GYNs Contracted |
| 01 | Barbour | North | 4 | 24 | 7 | 24 | 2 | 1 |
| 02 | Berkeley | East | 19 | 180 | 38 | 180 | 10 | 41 |
| 03 | Boone | South | 8 | 53 | 16 | 49 | 4 | 19 |
| 04 | Braxton | North | 4 | 60 | 7 | 58 | 2 | 2 |
| 05 | Brooke | North | 1 | 51 | 1 | 54 | 1 | 15 |
| 06 | Cabell | South | 38 | 395 | 75 | 369 | 19 | 51 |
| 07 | Calhoun | North | 2 | 21 | 4 | 19 | 1 | 0 |
| 08 | Clay | North | 4 | 45 | 8 | 45 | 2 | 3 |
| 09 | Doddridge | North | 2 | 18 | 3 | 17 | 1 | 0 |
| 10 | Fayette | South | 11 | 84 | 22 | 77 | 6 | 8 |
| 11 | Gilmer | North | 2 | 12 | 3 | 13 | 1 | 1 |
| 12 | Grant | East | 2 | 15 | 4 | 13 | 1 | 4 |
| 13 | Greenbrier | South | 7 | 128 | 14 | 114 | 4 | 6 |
| 14 | Hampshire | East | 4 | 29 | 8 | 21 | 2 | 2 |
| 15 | Hancock | North | 7 | 61 | 14 | 59 | 4 | 4 |
| 16 | Hardy | East | 3 | 25 | 5 | 26 | 2 | 2 |
| 17 | Harrison | North | 12 | 197 | 23 | 196 | 6 | 9 |
| 18 | Jackson | North | 8 | 74 | 15 | 65 | 4 | 3 |
| 19 | Jefferson | East | 7 | 67 | 13 | 69 | 4 | 4 |
| 20 | Kanawha | South | 55 | 558 | 109 | 501 | 28 | 55 |
| 21 | Lewis | North | 4 | 80 | 8 | 74 | 2 | 8 |
| 22 | Lincoln | South | 9 | 54 | 17 | 50 | 5 | 4 |
| 23 | Logan | South | 11 | 73 | 22 | 59 | 6 | 6 |

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***Figure D-2*** *(see caption below)*

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| County | # Members | # Providers | Provider/ Member Ratio | # w/ Access | # w/o Access | % w/ Access | % w/o Access | Avg. Dist. to 1 Prov. | Avg. Dist. to 2 Prov. |
|---|---|---|---|---|---|---|---|---|---|
| Barbour | 431 | 24 | 17.96 | 431 | 0 | 100.00% | 0.00% | 3.6 | 3.6 |
| Berkeley | 952 | 180 | 5.29 | 952 | 0 | 100.00% | 0.00% | 2.5 | 2.7 |
| Boone | 370 | 123 | 3.01 | 370 | 0 | 100.00% | 0.00% | 4.0 | 4.1 |
| Braxton | 276 | 276 | 1.00 | 276 | 0 | 100.00% | 0.00% | 3.2 | 3.3 |
| Brooke | 178 | 131 | 1.36 | 178 | 0 | 100.00% | 0.00% | 1.7 | 1.7 |
| Cabell | 1,408 | 1341 | 1.05 | 1,408 | 0 | 100.00% | 0.00% | 1.0 | 1.1 |
| Calhoun | 181 | 37 | 4.89 | 181 | 0 | 100.00% | 0.00% | 6.2 | 6.5 |
| Clay | 311 | 318 | 0.98 | 311 | 0 | 100.00% | 0.00% | 3.9 | 4.0 |
| Doddridge | 91 | 39 | 2.33 | 91 | 0 | 100.00% | 0.00% | 3.7 | 3.8 |
| Fayette | 824 | 229 | 3.60 | 824 | 0 | 100.00% | 0.00% | 2.6 | 2.6 |
| Gilmer | 78 | 27 | 2.89 | 78 | 0 | 100.00% | 0.00% | 4.8 | 5.5 |
| Grant | 140 | 45 | 3.11 | 140 | 0 | 100.00% | 0.00% | 3.8 | 4.1 |
| Greenbrier | 458 | 300 | 1.53 | 458 | 0 | 100.00% | 0.00% | 3.1 | 3.1 |
| Hampshire | 259 | 61 | 4.25 | 259 | 0 | 100.00% | 0.00% | 4.6 | 5.2 |
| Hancock | 260 | 84 | 3.10 | 260 | 0 | 100.00% | 0.00% | 1.3 | 1.6 |
| Hardy | 257 | 62 | 4.15 | 257 | 0 | 100.00% | 0.00% | 3.8 | 3.9 |
| Harrison | 913 | 857 | 1.07 | 913 | 0 | 100.00% | 0.00% | 1.7 | 1.7 |
| Jackson | 649 | 342 | 1.90 | 649 | 0 | 100.00% | 0.00% | 3.8 | 4.4 |
| Jefferson | 353 | 122 | 2.89 | 353 | 0 | 100.00% | 0.00% | 2.6 | 2.6 |
| Kanawha | 2,561 | 1705 | 1.50 | 2,561 | 0 | 100.00% | 0.00% | 1.6 | 1.7 |
| Lewis | 263 | 150 | 1.75 | 263 | 0 | 100.00% | 0.00% | 2.9 | 2.9 |
| Lincoln | 529 | 147 | 3.60 | 529 | 0 | 100.00% | 0.00% | 3.8 | 4.3 |
| Logan | 705 | 173 | 4.08 | 705 | 0 | 100.00% | 0.00% | 2.8 | 3.0 |
| Marion | 777 | 241 | 3.22 | 777 | 0 | 100.00% | 0.00% | 1.9 | 2.0 |
| Marshall | 285 | 110 | 2.59 | 285 | 0 | 100.00% | 0.00% | 2.1 | 2.2 |
| Mason | 336 | 96 | 3.50 | 336 | 0 | 100.00% | 0.00% | 3.9 | 4.4 |
| McDowell | 326 | 75 | 4.35 | 326 | 0 | 100.00% | 0.00% | 3.4 | 4.0 |
| Mercer | 1,015 | 312 | 3.25 | 1,015 | 0 | 100.00% | 0.00% | 1.8 | 2.0 |
| Mineral | 255 | 24 | 10.63 | 255 | 0 | 100.00% | 0.00% | 2.1 | 2.6 |
| Mingo | 459 | 97 | 4.73 | 459 | 0 | 100.00% | 0.00% | 3.6 | 4.4 |
| Monongalia | 622 | 776 | 0.80 | 622 | 0 | 100.00% | 0.00% | 1.6 | 1.8 |
| Monroe | 157 | 54 | 2.91 | 157 | 0 | 100.00% | 0.00% | 4.2 | 4.3 |
| Morgan | 147 | 42 | 3.50 | 147 | 0 | 100.00% | 0.00% | 4.4 | 4.5 |
| Nicholas | 581 | 140 | 4.15 | 581 | 0 | 100.00% | 0.00% | 3.7 | 3.8 |
| Ohio | 434 | 346 | 1.25 | 434 | 0 | 100.00% | 0.00% | 1.0 | 1.2 |
| Pendleton | 72 | 22 | 3.27 | 72 | 0 | 100.00% | 0.00% | 6.7 | 8.2 |
| Pleasants | 97 | 41 | 2.37 | 97 | 0 | 100.00% | 0.00% | 3.1 | 3.8 |
| Pocahontas | 103 | 236 | 0.44 | 103 | 0 | 100.00% | 0.00% | 2.8 | 3.6 |
| Preston | 457 | 129 | 3.54 | 457 | 0 | 100.00% | 0.00% | 3.1 | 3.2 |
| Putnam | 632 | 321 | 1.97 | 632 | 0 | 100.00% | 0.00% | 2.4 | 2.5 |
| Raleigh | 1,328 | 412 | 3.22 | 1,328 | 0 | 100.00% | 0.00% | 1.9 | 2.1 |
| Randolph | 562 | 183 | 3.07 | 562 | 0 | 100.00% | 0.00% | 2.6 | 2.7 |
| Ritchie | 182 | 40 | 4.55 | 182 | 0 | 100.00% | 0.00% | 4.6 | 4.6 |
| Roane | 270 | 80 | 3.38 | 270 | 0 | 100.00% | 0.00% | 4.5 | 5.2 |
| Summers | 163 | 35 | 4.66 | 163 | 0 | 100.00% | 0.00% | 3.8 | 3.9 |

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***Figure D-2:*** *As a long-term West Virginia MCO, and as current administrator of the Mountain Health Promise program, we have a robust network and history of submitting timely and compliant network standards documentation and geographic mapping reports.*

## Screening for excluded parties [MR019]

**The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs.**

Aetna's established screening processes are consistent with applicable federal and State requirement and designed to make certain we don't hire or contract with entities that are prohibited, suspended, debarred, or excluded from participating in Medicare, Medicaid, or other federal health care programs.

At the time of hire or contracting, and monthly thereafter, we screen all employees, providers, and vendors and providers against all required databases such as the Government Services Administration's System for Award, Office of Inspector General's List of Excluded Individuals/Entities, and state Medicaid excluded parties lists. Results of initial and ongoing screening are reviewed by our Vendor Delegated Oversight Committee, Credentialing Committee, Human Resources, Compliance and Legal Departments, as applicable.

We don't hire or contract with any individuals or entities that have been debarred, suspended, or otherwise lawfully prohibited from participating in any federal or state health care programs, or public procurement activity or non-procurement activities. If we identify an excluded party, we will promptly report such individuals to all required oversight agencies.

## Records retention process [MR020]

**The Vendor must establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department.**

Aetna's established record retention process complies with applicable federal and State requirements, as defined by DHHR. We will retain records for at least 10 years from the date of expiration or until any ongoing audits have been settled, if longer. If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the 10-year period, we will retain the records until completion of the action and resolution of all issues which arise from it, or until the end of the regular 10-year period, whichever is later. We agree to, and require our subcontractors to, retain the source records for data reports for a minimum of 10 years and to have written policies and procedures for storing this information.

Our currently participating West Virginia practitioners agree via their contracts to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards.

## Quality assessment and performance improvement program [MR021]

**The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department.**

Aetna has implemented and will maintain a Quality Assessment and Performance Improvement (QAPI) program as defined by DHHR. We monitor outcomes of all our quality improvement plans through our QAPI program. Each project has a plan to identify goals, project tasks, defined roles and responsibilities, and outline budget and necessary resources needed. The quality management and provider relations staff work together to monitor network practitioner and provider performance, including SNS providers. Quality management staff assists provider relations staff in developing measurable objectives across all populations, including foster care and children with special needs, to evaluate provider performance, analyze data collected in the monitoring process, and prepare information for the Quality Management Oversight Committee.

We currently have three Mountain Health Promise specific performance improvement projects:

- Care for Adolescents (topic chosen by the state)
- Annual Dental Visits (topic chosen by the state)
- Reducing Out of State Placements in Foster Care (topic chosen by Aetna).

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The baseline measurement period was 2021 for Care for Adolescents and Annual Dental Visit. Qlarant, the External Quality Review Organization, scored all three performance improvement projects as meeting requirements and having a high confidence level. **Between February 2020 and August 2022, total residential placements deceased by 10.8%. In-state residential placements decreased by 9.76% and out-of-state residential placements decreased by 25.73%.**

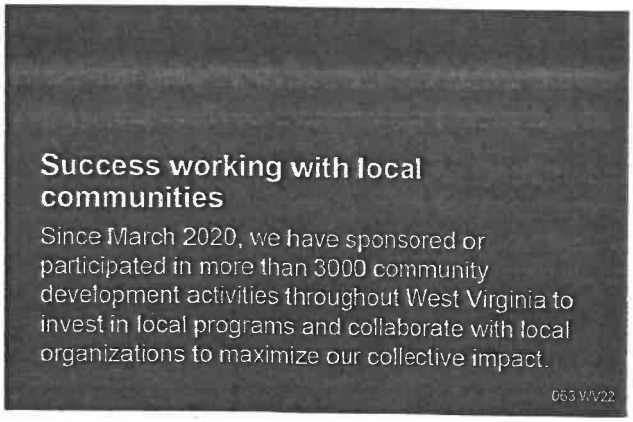
Our QAPI program has a comprehensive set of policies and procedures that address the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, with selecting subcontractors, and with ongoing monitoring of subcontractor performance.

We have expanded our QAPI monitoring activities to include measurement of the quality and performance of services delivered by SNS providers with careful attention not to overburden their care delivery for Mountain Health Promise members. Our goal is to collaborate with the SNS providers to provide timely, comprehensive, and quality services to these vulnerable members. We formally monitor delegation oversight activities for SNS providers as a component of the QAPI program. Audit reports of delegated activities and CAPs, if applicable, are submitted to the appropriate oversight committee (e.g., Quality Management/Utilization Management Committee, Delegation Subcommittee, and our National Vendor Delegate Oversight Committee) for review and approval and then to the Quality Management Oversight Committee, chaired by our CEO. The committee provides executive oversight of the QAPI program and makes recommendations to the board of directors about quality management and performance improvement activities.

## Participation in public meetings and other events [MR022]

**The Vendor must participate in public meetings and other events at the request of the Department.**

Aetna will continue to participate in public meetings and other events at the request of DHHR. We know that consistent, meaningful engagement with communities and stakeholders in every part of the state is critical to our success in serving West Virginia's most vulnerable residents. Due to the public health emergency that started 12 days after the start of the Mountain Health Promise, we quickly adapted to participating in meetings virtually.




Throughout the last three years, we have not only attended meetings and events as requested by DHHR, Aetna has also worked to outreach and engage a wide range of community partners across the state, such as state agencies, courts and legal entities, advocacy groups, community-based organizations, and providers. A few of the public meetings that we regularly attend include:

- Family Resource network meetings
- West Virginia ACEs Coalition meetings
- Judicial meetings
- CASA.

We have also created several mechanisms to ensure members, their families and other key stakeholders are engaged and that we have dedicated forums to receive their input. These meetings include the Member Advisory Committee, Grandfamilies Group, Children and Family Advisory Community Forums, SNS, and RTS focus groups.

We are deeply invested in the communities we serve, as demonstrated by our success in engaging and collaborating with a wide range of agencies, local organizations, Mountain Health Promise members and their families, and other stakeholders. We continuously work to identify and engage with new entities, to strengthen our relationships, and aid in facilitating cross-collaboration of all involved parties.

## Monthly meetings during first year of implementation [MR023]

**The Vendor must meet with the Department and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by the Department.**

As we did during the initial implementation of the Mountain Health Promise program, Aetna will meet with DHHR and industry-specific provider councils monthly during the first year of implementation, as requested by DHHR. As we have throughout the last three years, we will work collaboratively with DHHR and participate in meetings more frequently when asked. For example, we currently participate in:

- Weekly meetings with the BSS Mountain Health Promise liaison
- Bi-weekly meetings with the BSS program managers
- Monthly meetings with the BSS Commissioner
- Bi-weekly meetings with DHHR leaderships
- Bi-weekly meetings with the West Virginia Foster Care Ombudsman.

Aetna has also participated, upon request of DHHR, in a variety of other State Government meetings. For example, members of our leadership team recently provided a presentation to the West Virginia State Legislature, and we participate on weekly R3 meetings regarding the Department of Justice agreements.

We have established long term relationships with many provider councils that precedes our time as the Mountain Health Promise MCO. Over the last three years, we have continued to work with these councils to specifically address needs of the Mountain Health Promise members. A few of the provider councils and advocacy groups that we work with include:

- West Virginia Primary Care Association
- West Virginia Behavioral Health Providers Association
- West Virginia Association of Addiction Counselors
- West Virginia Childcare Association
- West Virginia Perinatal Partnership
- SNS Provider Association
- West Virginia ACEs Collation
- West Virginia System of Care.

These councils assist us in engaging providers and advocates with expertise in services for children, youth, and families and are involved in providing on-the-ground services to members. The collaboration

and coordination actives include outreach, education, and training to remove barriers to care coordination and improved service for children and youth members involved in foster care, child protection, adoption assistance, and juvenile justice.

## Quarterly meetings after the first year of implementation [MR024]

**The Vendor must meet with the Department and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by the Department.**

Aetna will continue to meet with DHHR and industry-specific provider councils on a quarterly basis as requested by DHHR. We attend several meetings on a quarterly basis, including CSED Quality Improvement meetings, BMS meetings, and West Virginia Behavioral Health and West Virginia Childcare Associations meetings.

As described in our response to MR022 and MR023 in this response, we have participated in and hosted meetings and activities with numerous entities across the State, including DHHR and industry-specific provider councils. We use these meetings to identify and address current pain points and general concerns, to monitor current trends, and collaboratively problem solve challenges. Over the last three years, we have exceeded this requirement by participating in meetings on a weekly, bi-weekly, or monthly basis to make sure we are effectively collaborating with state agencies, providers, advocates, members, families, and other stakeholders.

## External quality reviews [MR025]

**The Vendor must participate in external quality reviews in alignment with federal and State requirements, as defined by the Department.**

Aetna participates in external quality reviews (EQRs) in alignment with federal and State requirements, as defined by DHHR. Our director of quality improvement works closely with the compliance officer in facilitating external quality reviews and both serve as critical resources to all operational areas assuring alignment with both federal and State requirements. **Aetna achieved a 4 Star rating on our recent NCQA re-accreditation review, making us the only 4 Star Medicaid plan in West Virginia.**

PROVEN RECORD OF EQR SUCCESS
**We have scored 100% on 7 of our last 8 EQRs and scored 99% compliant in the remaining year.**

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We comply with DHHR requirements for regular reporting and annual EQR consisting of an onsite systems performance review of quality outcomes, timeliness of, and access to services. We make every effort to comply with EQRs implemented by any organization, such as Qlarant, with which DHHR contracts, including such activities as:

- Participating in the design of the external review
- Collecting medical records and other data
- Making data available to the EQRO.

We currently have three Mountain Health Promise specific performance improvement projects:

- Care for Adolescents (topic chosen by the state)
- Annual Dental Visits (topic chosen by the state)
- Reducing Out of State Placements in Foster Care (topic chosen by Aetna).

Aetna and our subcontractor(s) will make available to BMS as contractually required and upon request all data, clinical and other records/reports for review of quality of care, access, and utilization issues including, but not limited to, activities related to EQR, HEDIS, encounter data validation, and other related activities.

## Oral presentations [MR026]

The Vendor must participate in the oral presentations to be scheduled during the proposal scoring period. Proposed key staff must be present for orals, in lieu of corporate or sales personnel being the primary participants.

Aetna will participate in the oral presentations to be scheduled during the proposal scoring period. Our proposed key staff will be present for orals, in lieu of corporate or sales personnel being the primary participants. We will carefully consider and include in our oral presentation individuals who are knowledgeable about the State's requirements and the Children and Youth project population.

## Providing all requested information [MR027]

The Vendor must provide all requested information prior to and participate in a readiness review, which will be defined by the Department, prior to implementation.

Aetna will provide all requested information prior to and participate in a readiness review, as defined by DHHR. When implementing the initial Mountain Health Promise program, **we achieved nearly 95% readiness within 4 months, exceeding the 75% implementation requirement.** We have also demonstrated our success working with DHHR to implement new programs and program changes such as carving in behavioral health services, and children and adult dental services. Our proven implementation process illustrates our diligence and consistency in meeting state documentation and process needs leading to successful implementation of services for members.

Our local team is supported by **the Aetna Medicaid six sigma implementation team, program, and system, which has not failed a readiness review.** Combining our team of local West Virginians and our national implementation expertise, will ensure we will work collaboratively with DHHR upon contract award to successfully participate in the readiness review process, including such activities as:

- Review and approval of all our policies and procedures and member materials
- Demonstration of our systems
- Explanation of Value-added services
- Thorough review of our health plan's understanding of the contractual requirements
- Reviews onsite, desktop reviews, policy reviews, system demonstrations, staff interviews, and self-audit evaluations
- Review of pre-delegation audit materials and readiness of vendors.

## Current and future security policies and procedures [MR028]

The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following link: http://www.wvdhhr.org/mis/policies.asp; https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx

Aetna will continue to comply with all current and future security policies and procedures of DHHR and the West Virginia Office of Technology (WVOT) found at the provided linked websites. **Aetna successfully completed 2022 Information System Capabilities Assessment West Virginia**

**Performance Measures Validation.** We exceed industry standards with robust information security policies, procedures, and standards based on the types of information we need to protect, the users of that information, and applicable laws and regulations. We support customer assessments of our security program and standards and stays current with technological advances to determine if we have adequately addressed specific expectations. Access to a copy of our policies, control standards, and procedures is available upon State request.

## Compatibility with WVOT versions and standards [MR029]

The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.

Aetna will continue to ensure our compatibility with the most current WVOT-supported versions and standards. Protecting member data—keeping all information safe and secure—is of utmost importance. We treat each member as an individual, thoughtful consumer; they aren't just statistics or data figures to us. As such, we push our global cybersecurity program beyond what is standard for our industry. We improve security while making it more convenient for each individual and we continue to invest in practices, processes, and controls to stay a step ahead of an ever-evolving issue. We commit to provide access to best practice health care for Children and Youth project members while diligently protecting their privacy. On a weekly and monthly basis we successfully transfer files to and from DHHR. These files are supported and are compatible with our systems, and include the following:

- 837 encounter file (weekly)
- The 837-encounter file also includes vendor encounter information for both children's dental and vision benefits
- 834 enrollment file (monthly)
- 820 and 835 payment files (monthly).

We submit weekly HIPAA compliant encounter files to DHHR's vendor, which include information from our delegated subcontractors. On a weekly basis we send to Maximus, the State's enrollment broker, a provider file to make sure members receive up-to-date provider information ensuring accurate member selection of PCPs.

In addition, we receive the following files helping to make sure providers are accredited to State guidelines:

- Prov 12: complete provider listing of all accredited West Virginia providers (monthly)
- Prov 98: provides newly created, termed, and pay-hold providers on a weekly basis.

These reports help us ensure proper claims administration payment and provider credentialing. We also receive daily pharmacy files that allow us to provide member care and medical management integrated into our physical and behavioral health care focused on the needs of children and youth.

## HIPAA compliance [MR030]

The Vendor must provide a plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.

Aetna will continue to provide a plan for how we maintain full HIPAA compliance, which we will maintain throughout the life of the contract, at no additional cost to DHHR. We have policies, procedures, and

practices to support compliance with HIPAA requirements and to ensure privacy of protected health information. We require every employee to complete annual training and demonstrate understanding of these requirements. We update our Medicaid compliance plan annually and submit it to DHHR prior to October first. We also require committee members, such as our Quality Management/Utilization Management Committee, to sign confidentiality statements.

Business managers in each area work the privacy manager to monitor business-specific privacy training. We also make certain that each staff member completes annual Business Conduct and Integrity training through monitoring by the hiring manager, business compliance officer and corporate compliance. We make certain that records are confidential and when releasing records to members or other providers and that we meet all HIPAA standards, including obtaining the appropriate signatures for their release. This is particularly important to support coordination of care for our Mountain Health Promise members. Our plan includes the following operational element details and discussion illustrating how we will continue to ensure compliance with DHHR requirements throughout the life of the contract:

- Written policies, procedures, and standards of conduct, including privacy policies concerning securing member's protected health information and individuals' right to request restrictions and confidential communications
- Description of compliance officer, Compliance Committee and high-level oversight duties and responsibilities
- Description of effective training and education procedures
- Description of communication processes
- Description of well-publicized disciplinary standards
- Description of effective system for routine monitoring and identification of compliance risks
- Written procedures and system infrastructure support for prompt response to compliance issues.

## Confidentiality and privacy [MR031]

**The Vendor must comply with applicable State and federal law regarding confidentiality/privacy, including, but not limited to, the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements), 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy), to the extent they apply.**

In addition to Tanya Cyrus, our locally designated privacy officer, we are supported by the Aetna Medicaid Privacy Officer and Security Officer. We have policies, process, and controls to support compliance with applicable West Virginia and federal law regarding confidentiality/privacy, including, but not limited to, the following:

- Confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act
- Information safeguarding requirements of title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 C.F.R. 431 F); and Title 45, Parts 160 (General Administrative Requirements], 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy).

Our staff complete an annual training entitled Privacy Training for Aetna Colleagues, which provides training on protecting the confidential information of members, colleagues, and the company as a high priority at CVS Health. This course reviews the important policies regarding handling, protecting, and

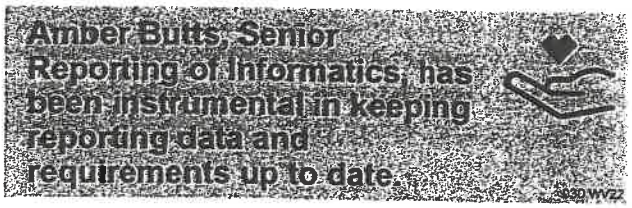
safeguarding confidential information including those listed legal requirements. Since we began administering the Mountain Health Promise program in March 2020, we have not experienced a data breach.

## Incorporating all mandated federal and state requirements [MR032]

**The Vendor must agree to incorporate all requirements mandated through federal and State regulations and legislation, which will include, but not be limited to, new reporting requirements.**

Aetna agrees to incorporate all requirements mandated by federal and State regulations and legislation, which include, but not limited to, new reporting requirements, including those identified in Attachment D of the Service Provider Agreement and West Virginia Code §9-5-27, such as:

- Quality reporting
- Provider reporting
- Financial reporting
- Federal reporting
- Any new reporting requirements for the Mount Health Promise contract
- Other State-required reporting including those required related to advisory councils.




We have established policies and procedures to support State reporting requirements pertaining to all ad hoc and contractually mandated regulatory reporting and establishes guidelines for regulatory reporting in accordance with State regulatory specifications. Our Business Information Management's Reporting Management team is responsible for monitoring plan data to confirm the data conforms to specified formats and reporting requirements. They also confirm that third-party reporting services are held accountable for complete, accurate, and timely data reporting that meets DHHR requirements. The Reporting Management team is also responsible for maintaining a current list of regulatory report requirements on the data hub to assure we meet any new reporting requirements as they are implemented.

## Compliance support services [MR033]

**The Vendor must provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing.**

Aetna will continue to provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing. We have protected the integrity of our operations for the past 26 years and will continue to do so. **Aetna submits over 250 Mountain Health Promise reports annually.** We achieve compliance with data integrity requirements through a robust and coordinated committee structure that includes our Policy and Procedure, Compliance, Service Improvement, Quality Management and Utilization Management, and Quality Management Oversight Committees. We also hold monthly 'Reach Team' meetings to provide focused review of compliance with specific topic areas such as utilization management, population health, behavioral health, and member experience. The Quality Management Team facilitates all 9 Reach Teams, which include representatives from across the organizations

department and are organized by topic, to provide a focused review of specific requirements with key stakeholders "at the table." By having these committees and Reach Team meetings, we can respond with up-to-date, accurate, and thorough documentation to all audits in an efficient manner.

We actively participate in an external independent review performed by DHHR-BMS. We provide BMS with access to site, information, documentation, and data. Aetna and our subcontractor(s) will continue to make available to BMS as contractually required and upon request all data, clinical, and other records/reports for review of quality of care, access, and utilization issues including, but not limited to, activities related to EQR, HEDIS, encounter data validation, and other related activities.

## Compliance with Section 508 of the Rehabilitation Act of 1973 [MR034]

**The Vendor must ensure that all applications inclusive of internet, intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22.**

Aetna will continue to ensure all our applications inclusive of internet, intranet, and extranet applications associated with this contract are compliant with the following requirements:

- Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, related to ensuring accessibility of internet, intranet, and extranet applications for people with disabilities
- 36 C.F.R. 1194.21, related to reducing barriers to electronic resources such as the internet, intranet, and extranet for those with disabilities
- 36 C.F.R. 1194.22 related to complying with accessibility standards to electronic communications for members.

We perform regular internal accessibility compliance audits of our applications to ensure we remain compliant with these requirements. We take seriously maintaining accessibility of communications to members with disabilities regarding electronic communications and resources. In serving Medicaid membership since 1996, we have experience in providing resources to individuals with physical, intellectual, behavioral, visual, and hearing-oriented disabilities and work diligently to ensure equal access.

## Data retention and accessibility [MR035]

**The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) are retained and/or accessible according to the federal requirements in 45 Code of Federal Regulations (CFR) Part 75 and/or applicable State and/or federal requirements.**

Aetna will continue to ensure the data we enter, maintain, or generate meets the requirements of this RFP are retained and/or accessible according to the federal requirements in 45 C.F.R. Part 75 and/or applicable State and/or federal requirements. We understand the importance of the retention, maintenance, and accessibility of data related to federal and State contract awards and funding to assure effective and efficient use of finite, public Medicaid funding sources. We will continue to follow the Mountain Health Promise contract and retain required information for 10 years, or a longer in the event of an audit or litigation. We have established policies, procedures, and practices that address State and federal requirements, including those contained in Article III, Section 8 of the Service Provider Agreement. We also require our subcontractors to contractually agree to comply with these data retention and accessibility requirements.

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## Approval for all key staff hired and personnel assigned [MR036]

The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications.

Aetna will continue to obtain approval from DHHR for all key staff hired, and personnel assigned under the contract. We replace key staff only with persons of equal or greater experience and qualifications. For each position staffed within this project, we will continue to seek to hire individuals with child and welfare program expertise and understanding to optimally serve Mountain Health Promise members. We will continue to collaborate with the State to enhance and advance the positions to support the program and advance service continually and fully to the members.

## Key staff employment requirements [MR037]

The Vendor must employ Key Staff assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within 30 calendar days of the contract award.

**We are ready in full compliance with the requirement for all key staff members to enter the project within 30 calendar days of the contract award as 100% of all key staff positions are currently filled with West Virginians.** Aetna understands and will continue to comply with requirements that each key staff role be a full-time position, filled by one staff member only, unless otherwise approved by the department. As described in response to MR039 in this response, we fill key staff vacancies with 30 business days.

## Notice of staffing changes [MR038]

The Vendor must provide the Department a minimum of ten (10) business days' notice for staffing changes.

Aetna's established processes ensure we provide DHHR with a minimum of 10 business days' notice of any staffing changes. A key component of maintaining continuity of services is thorough succession planning in anticipation of potential staffing changes and creating cross-functional capability whenever possible. To assure continuity of services we identify potential interim replacements, when applicable, to maintain continuity of program administration and personnel management in concert with our philosophy of a trauma-informed system of care.

## Replacement of key staff within 30 business days [MR039]

The Vendor must replace key staff within 30 business days after the position is vacant, unless a longer period is approved by the Department.

Aetna will continue to make sure we replace key staff within 30 business days after a position is vacant, unless DHHR approves a longer period. Aetna has maintained a low-key staff turn-over rate and our **established project team for the Mountain Health Promise program has over 400 years' dedicated West Virginia health plan and Medicaid experience combined.** We always strive to identify interim replacements to assume essential functions during the hiring and replacement process. These interim assignments are filled by experienced professionals with applicable knowledge, experience, and skills to perform the position duties effectively and without service disruption.

## Ensuring operations are efficient, professional, legal, and secure [MR040]

The Department has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Department determines that any such staff has interfered or may interfere with the Department's interests identified above.

Aetna understands DHHR has an interest in ensuring we carry out operations in an efficient, professional, legal, and secure manner. **We have never had a staff member removed due to DHHR determining they have interfered with DHHR's interest.** In the unlikely event that DHHR were to determine a staff interferes or may interfere with DHHR's interest, we understand and agree to remove such staff from the project. We will continue to collaborate with DHHR's interests in carrying out operations in an efficient, professional, legal, and secure manner. We will make these efforts to protect the State's investment and service to members and help to assure their best possible outcomes.

## Financial, legal, ethical, and all other forms of responsibility [MR041]

The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with Vendor on the project.

Aetna accepts financial, legal, ethical, and all other forms of responsibility for the conduct of all our business partners, independent contractors, subcontractors, and other entities supporting us or working with us on the project. Our established subcontractor oversight program supports effective oversight at all stages, starting with assessing whether and which subcontractors we will use, through contracting and oversight of performance, and assuring smooth transition in the event of a termination. Our contracts include appropriate service level agreements that we customize to the specific functions each subcontractor performs and the applicable requirement and expectations and include provisions to address potential non-compliance such as CAPs, monetary penalties, and termination.

## Accessing, editing, or sharing personal information controls [MR042]

The Vendor must have controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. Personal information data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Administration (SSA) data (including, but not limited to, family, friends, and acquaintance information).

Aetna will continue to have controls in place to ensure that unauthorized staff and other users don't have the capability to access, edit, or share personal information data. We understand personal information data includes, but isn't limited to protected health information, personally identifiable information, federal tax information, and Social Security Administration data (including, but not limited to, family, friends, and acquaintance information). We fully protect member privacy and data within our systems. We require every employee to complete annual compliance training on the stated requirements. Our entire organization, including Medical Management, Member Services, Quality Management, Provider Relations, and if applicable, Care Management, and Utilization Management departments are responsible for implementing the oversight process and maintaining monitoring activities, including monitoring the delegate's provisions to safeguard members' PHI, as applicable.

We have the proper controls in place to ensure that unauthorized staff and other users don't have the capability to access, edit, or share personal information data. We take a risk-based approach to information security management. Asset criticality and data classification determine level of protection and quarterly risk assessments. This is derived from daily threat and vulnerability reviews. Our approach allows us to keep abreast of key risks and threats and to focus on managing the top key

risks. Our resulting security control environment lays the foundation for data protection, and our innovative solutions result in a level of protection typically found only within the financial industry and other highly regulated environments.

Some of the most directly relevant components of our security program include the following:

- Social Security number reduction/protection program
- Encryption of data in motion and at rest
- Application and web security controls
- Data security controls
  - Layered encryption strategy
  - Secure hardware disposal
  - Data loss prevention systems
- Physical security controls
  - Secure access management (pre-registration, identity authorization, business need validation); physical security monitoring (closed-circuit television cameras, 24/7/365 security guard, etc.)
  - Access controls (card readers, anti-pass-back, tailgate detection, etc.)
- Enhanced security monitoring controls
  - Database access security monitoring
  - Centralized Security Information and Event Management with 24/7/365 monitoring
  - Host and network intrusion detection and prevention systems
- Software lifecycle security hardening controls
- Access management
- Centralized role-based access
- Privileged account management
- Privileged user monitoring
- Email security
  - Email encryption
  - Email/Domain Name System security standards
  - Inbound/Outbound email: malicious code controls, proof point email gateway
- Third party/Vendor governance.

## Vendor employee confidentiality statement [MR043]

The Vendor must ensure that all project staff have completed a Department Office of Management Systems (OMIS) Vendor Employee Confidentiality Statement (VECS) before beginning work on the project.

Aetna will continue to ensure that all project staff complete a DHHR Office of Management Systems Vendor Employee Confidentiality Statement (VECS) before beginning work on the project. If the DHHR requests to see the VECS, we have easily accessible and on file. We are committed to operational integrity in collaborating with the DHHR and will ensure that all project staff has completed a DHHR Office of Management Systems VECS prior to beginning work on the project. Assuring the integrity of

the State's management systems from breaches of confidentiality is core to our maintaining confidential member protected health information.

## Federal Executive Order 11246 [MR044]

The Vendor must comply with Federal Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act.

Aetna will continue to comply with the requirements of Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act. We provide assurance that we don't discriminate in employment decisions based on race, color, religion, sex, sexual orientation, gender identity, or national origin. We use a variety of recruiting efforts to develop and ensure we maintain a diverse workforce creating career opportunities for people without discrimination, such as discrimination based on race, religion, color, national origin, age, sex, or disability, minority, and ethnic groups. We hold regional and/or virtual job fairs with screening sessions to evaluate potential candidates and develop regional marketing efforts to recruit staff. We collaborate with recruiting agencies and job-training organizations and focus on recruiting diverse individuals through these local relationships. We believe that solving for the challenges of an increasingly complex health care environment requires the creativity and insights that only an inclusive, diverse workplace can deliver.

We also comply with environmental regulations within the Clean Air Act and Clean Water Act. We cooperate with government agencies and communities in environmental protections efforts and comply with environmental laws and regulations. We ensure all environmentally sensitive and hazardous materials are identified and managed to ensure their safe handling, movement, storage, recycling or reuse and disposal.

## Drug-free workplace [MR045]

The Vendor must provide a drug free workplace for employees and all applicable agents, including, but not limited to, subcontractors. All agents of the Vendor must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract.

Aetna maintains a drug-free workplace for employees and all applicable agents, including, but not limited to, subcontractors. We comply with requirements to make certain all agents don't engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract. Employees are expected to report to work free from the negative effects of drug or alcohol use and be able to fully perform their work duties.

If an employee is convicted or pleads no contest to a drug-related crime occurring in the workplace, they are required to tell their manager within five days of the conviction or plea. If employees need help with alcohol- or drug-related problems, our Resources for Living program is available to provide the following services:

- Assessment
- Counseling
- Referral resources.

We prohibit the following conduct while working or on company premises including buildings, parking lots, or other properties used by the company:

- Engaging in the unlawful or inappropriate manufacture, distribution, dispensation, possession, use, transfer, solicitation, purchase, or sale of alcoholic beverages, controlled substances, and/or illegal or prescribed drugs
- Reporting to or remaining at work under the influence of alcohol or controlled substances, except when prescribed by a physician and use doesn't negatively affect an individual's ability to perform their job
- Unauthorized use or possession of alcohol, drugs, or any controlled substance, except when prescribed by a physician
- Testing positive for controlled substances except for legally prescribed medications
- Refusing to undergo drug and/or alcohol testing.

We screen all personnel as part of the pre-employment hiring process. We make certain that all staff, agents, and subcontractors don't engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract. We also provide an employee assistance program that provides services and supports regarding substance abuse.

To assure compliance with this requirement for our subcontractors, we have a system of subcontractor monitoring to bring extensive oversight to their processes including ensuring a safe and drug-free workplace.

## HIPAA compliance officer [MR046]

The Vendor must designate one named individual in its proposal as the Vendor Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance officer.

Tanya Cyrus, RN, is the Aetna designated HIPAA compliance officer. Tanya has over 20 years of experience in health care administration and oversight. Her expertise includes engaging with legal and program leadership, conducting health care educational programs, and interacting with facility and medical staff at all levels.

## Approval for use of the Department's name [MR047]

The Vendor must not publish or copyright any data using the Department's name without prior written approval by the Department for every instance. In this context, ""data"" shall mean all results, technical information and materials developed and/or obtained in the performance of the services hereunder, including but not limited to: all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder. Except with respect to any commercial software, the Department will be and remain the owner of all data provided to the Department by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records.

Aetna will continue to comply with State requirements to not publish or copyright any data using DHHR's name without prior written approval by DHHR for every instance. We understand the importance of protecting State-owned data and the definitions of data provided by DHHR as we make certain to secure and protect data where appropriate in accord with all State requirements.

## Expenses required to access department systems [MR048]

The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs.

Aetna complies with and understands we are responsible for all expenses required to obtain and maintain access to DHHR systems. We understand these expenses include, but aren't limited to, hardware, software, network infrastructure, and any licensing costs. We have successfully managed and integrated with West Virginia Medicaid IT systems throughout our history of serving the State through the Mountain Health Promise and Mountain Health Trust contracts.

## Availability of third-party audit results [MR049]

The Vendor must make available to the Department the results of any third-party audit conducted, including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization.

Aetna complies with and will continue to make available to DHHR the results of any third-party audit conducted, including, but not limited to, our Service Organization Control 2 review results. We perform comprehensive penetration testing and vulnerability scanning, and we are happy to share numerous software security attestations, such as security scorecard reports, penetration test reports and BSIMM assessments. Other assessments available include the following: HIPAA, SIG, NIST 800-53, security control assessment, and cyber security framework. We can provide all assessments indicated upon State request.

In addition to providing our current third-party independent assessments, a copy of our policies, control standards and procedures are available upon member request. If additional information is needed, we welcome DHHR to attend an onsite day event for further information on our security and technology programs, data center tours, and evidence reviews to satisfy yearly assessments.

As described in the response to MR008, we recently completed our NCQA reaccreditation review and achieved a 4 Star rating.

## Authorization to access records [MR050]

The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract.

Aetna will continue to comply with providing authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts our performance under the Mountain Health Promise contract. We have established policies and procedures to support timely response to requests by the State. We routinely respond to requests from BMS for certain documents in a timely manner. If the State determines that our relationship with a parent or affiliate impacts our performance under the contract, we will provide the State with applicable records.

## Administration of a Prior Authorization Program [MR051]

The Vendor should administer a prior authorization program in accordance with applicable law and Appendix 3: Service Provider Agreement. This includes, but is not limited to, United States Code 42 CFR § 438.210, West Virginia Code §33-25A-8s, and requirements for parity in mental health and substance use disorder benefits in 42 CFR § 438.910(d).

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Aetna administers our prior authorization program in accordance with applicable law and Appendix 3: Service Provider Agreement, including, but isn't limited to, United States Code 42 C.F.R. § 438.210, West Virginia Code §33-25A-8s, and requirements for parity in mental health and SUD benefits in 42 C.F.R. § 438.910(d). Our process include compliance with member and provider protections, such as the request an expedited review, provider requests for peer-to-peer review, member appeal rights, and the right to request a review by an independent review organization.

We use nationally recognized, evidence-based criteria (e.g., Milliman Care Guidelines) that is applied based on the needs of individual members and characteristics of the local delivery system. Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria.

Criteria sets are reviewed annually for appropriateness and applicability for West Virginia's children and youth involved in child welfare. We modify criteria as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate physical health and behavioral health medical directors, pharmacists, and practitioners in developing, adopting, or reviewing criteria. We advise members and providers that criteria are available upon request and free of charge in the Notice of Action, and the provider manual. **In 2021, we processed over 49,000 prior authorization requests for physical and behavioral services, excluding concurrent inpatient authorizations, with an average turnaround time of four days.**

We understand that we may place appropriate limits on the covered services provided under this Contract based on criteria applied under the Medicaid State Plan or BSS State requirements, such as medical necessity or for the purpose of utilization control, provided that:

- Services can reasonably be expected to achieve the purpose for which they are furnished
- Services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports
- Services for family planning are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.

We ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services were requested We have appropriate controls to:

- Prevent arbitrary denials or reductions in the amount, duration, or scope of required services based solely on diagnosis, type of illness, or condition
- Support compliance with other relevant requirements such as the Mental Health Parity and Addiction Equity Act of 2008 and EPSDT requirements.

We conduct comprehensive initial and ongoing training for UM staff who make medical necessity determinations to ensure consistency of reviews and compliance with applicable requirements. Only the medical director may determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

If DHHR overrides one of our UM guidelines on a case-by-case basis, our Medical Director with coordinate with DHHR Medical Director or BSS designee to complete a thorough review and implement appropriate overrides.

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## Mental health and SUD Parity

Aetna understands and has extensive experience complying with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and 42 C.F.R. 438 Subpart K, including 42 C.F.R. § 438.910(d). Our multifaceted approach to ensure ongoing compliance with MHPAEA is informed by our integrated behavioral health teams and national experience. Through our initiation of activities to comply with these laws in 2008, we conduct numerous legal reviews and comprehensive actuarial analyses resulting in fully compliant MHPAEA processes and systems.

Our national behavioral health Parity Task Force meets monthly and includes representatives from legal, behavioral health operations, medical operations, claims and network. The Parity Task Force reviews potential issues identified from a variety of internal sources, member and provider complaints, and regulators. As appropriate, we conduct a comprehensive comparative analysis for UM, medical necessity, benefits, and network. If differences are discovered, we take appropriate corrective action, including reporting to required agencies.

## West Virginia Code §33-25A-8s

Aetna has established a process to put providers on gold card status, or not require the provider to obtain prior-authorization of services in compliance with West Virginia Code §33-25A-8s. We place providers on gold card status for 6 months, upon the provider's request, when the have had 30 prior authorization approvals with no denials.

| Req ID # | Mandatory Requirements<br>Requirement Text | Vendor Response<br>Type | Vendor's Disposition | Attachment | Section | Page # |
|---|---|---|---|---|---|---|
| MR001 | The Vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, state or federal laws and regulations, waiver amendments, or State Plan amendments. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Compliance with all applicable requirements | 203 - 204 |
| MR002 | The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services. | Capitation Rate | Will Meet | Attachment D - Mandatory Requirements | Accepting State established rates | 204 |
| MR003 | The Vendor must have all requirements operational, as agreed upon with the Department, by January 1, 2020. | Implementation | Will Meet | Attachment D - Mandatory Requirements | Timely operationalization of all requirements | 205 |
| MR004 | The Vendor must comply with W.Va. Code §9-5-27 requirements, including, but not limited to, reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80% of the full-time equivalent positions are located. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Compliance with West Virginia Code §9-5-27 | 205 - 206 |
| MR005 | The Vendor must adhere to the case management decisions of the Department caseworker, multidisciplinary team (MDT), or court, but must document and provide all recommendations for case management, as appropriate. | Care Coordination | Will Meet | Attachment D - Mandatory Requirements | Adherence to Department caseworker decisions | 207 |
| MR006 | The Vendor must comply with requirements for qualified residential treatment program (QRTP) placements as described in the Service Provider Agreement (SPA). | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Qualified residential treatment program placements | 207 - 208 |
| MR007 | The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA), and serves all counties in the State. | Network Standards | Will Meet | Attachment D - Mandatory Requirements | Physical health and behavioral health provider network | 209 |
| MR008 | The Vendor must be accredited by the National Committee for Quality Assurance (NCQA). | Accreditation | Will Meet | Attachment D - Mandatory Requirements | NCQA accreditation | 209 - 210 |
| MR009 | The Vendor must provide all requested supporting documentation upon notification of award, or a later date as specified by the Department, according to the requirements described in Appendix 5: List of Requested Documents. | Readiness Review | Will Meet | Attachment D - Mandatory Requirements | Requested supporting documentation | 210 - 211 |
| MR010 | The Vendor must provide evidence of efforts to contract with all currently enrolled providers under the Department's fee-for-service (FFS) Medicaid program. | Network Standards | Will Meet | Attachment D - Mandatory Requirements | Evidence of efforts to contract with enrolled providers | 211 |
| MR011 | The Vendor must credential and re-credential new physical health and behavioral health providers in accordance with federal and State requirements, as defined by the Department. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Credentialing and re-credentialing | 211 - 213 |
| MR012 | The Vendor must ensure compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requirements for applicable members, as outlined in the Service Provider Agreement (SPA). | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Early and periodic screening, diagnosis, and treatment | 213 - 214 |
| MR013 | The Vendor must comply with post-stabilization care per applicable federal and State requirements, as defined by the Department. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Post-stabilization care | 214 |
| MR014 | The Vendor must provide 24-hour access to a provider or service in emergency situations. | Access to Care | Will Meet | Attachment D - Mandatory Requirements | 24-hour access to a provider or service in emergency situations | 215 |
| MR015 | The Vendor must, based on Department provider access to care requirements, ensure access to the full range of specialty and facility service providers for members in applicable populations with complex needs. | Access to Care | Will Meet | Attachment D - Mandatory Requirements | Access to the full range of specialty and facility service providers | 215 - 216 |
| MR016 | The Vendor must ensure that individuals in applicable populations who have specialists as primary care providers (PCPs) are receiving primary care services on an ongoing basis. | Benefit Administration | Will Meet | Attachment D - Mandatory Requirements | Ensuring receipt of primary care services | 216 |
| MR017 | The Vendor must monitor primary care provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) limit of Medicaid members assigned per PCP, for applicable populations. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Monitoring PCP panels for compliance | 216 - 217 |
| MR018 | The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA). | Network Standards | Will Meet | Attachment D - Mandatory Requirements | Network standards documentation and geographic mapping | 217 - 219 |

# Vendor's Responses to Mandatory Requirements

| Mandatory Requirements | | | | Vendor Response | | |
|---|---|---|---|---|---|---|
| Req ID # | Requirement Text | Type | Vendor's Disposition | Attachment | Section | Page # |
| MR019 | The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Screening for excluded parties | 219 - 220 |
| MR020 | The Vendor must establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department. | Data Retention and Accessibility | Will Meet | Attachment D - Mandatory Requirements | Records retention process | 220 |
| MR021 | The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department. | Quality | Will Meet | Attachment D - Mandatory Requirements | Quality assessment and performance improvement program | 220 - 221 |
| MR022 | The Vendor must participate in public meetings and other events at the request of the Department. | Stakeholder Engagement | Will Meet | Attachment D - Mandatory Requirements | Participation in public meetings and other events | 221 - 222 |
| MR023 | The Vendor must meet with the Department and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by the Department. | Stakeholder Engagement | Will Meet | Attachment D - Mandatory Requirements | Monthly meetings during first year of implementation | 222 - 223 |
| MR024 | The Vendor must meet with the Department and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by the Department. | Stakeholder Engagement | Will Meet | Attachment D - Mandatory Requirements | Quarterly meetings after the first year of implementation | 223 |
| MR025 | The Vendor must participate in external quality reviews in alignment with federal and State requirements, as defined by the Department. | External Quality Reviews | Will Meet | Attachment D - Mandatory Requirements | External quality reviews | 223 - 224 |
| MR026 | The Vendor must participate in the oral presentations to be scheduled during the proposal scoring period. Proposed key staff must be present for orals, in lieu of corporate or sales personnel being the primary participants. | Orals | Will Meet | Attachment D - Mandatory Requirements | Oral presentations | 224 |
| MR027 | The Vendor must provide all requested information prior to and participate in a readiness review, which will be defined by the Department, prior to implementation. | Readiness Review | Will Meet | Attachment D - Mandatory Requirements | Providing all requested information | 224 |
| MR028 | The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following link:<br>http://www.wvdhhr.org/mis/policies.asp<br>https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx | Security | Will Meet | Attachment D - Mandatory Requirements | Current and future security policies and procedures | 224 - 225 |
| MR029 | The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards. | Compatibility | Will Meet | Attachment D - Mandatory Requirements | Compatibility with WVOT versions and standards | 225 |
| MR030 | The Vendor must provide a plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department. | Security | Will Meet | Attachment D - Mandatory Requirements | HIPAA compliance | 225 - 226 |
| MR031 | The Vendor must comply with applicable State and federal law regarding confidentiality/privacy, including, but not limited to, the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements), 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy), to the extent they apply. | Security | Will Meet | Attachment D - Mandatory Requirements | Confidentiality and privacy | 226 - 227 |
| MR032 | The Vendor must agree to incorporate all requirements mandated through federal and State regulations and legislation, which will include, but not be limited to, new reporting requirements. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Incorporating all mandated federal and state requirements | 227 |
| MR033 | The Vendor must provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing. | Audit Compliance | Will Meet | Attachment D - Mandatory Requirements | Compliance support services | 227 - 228 |

| Mandatory Requirements | | | Vendor Response | | | |
|---|---|---|---|---|---|---|
| Req ID # | Requirement Text | Type | Vendor's Disposition | Attachment | Section | Page # |
| MR034 | The Vendor must ensure that all applications inclusive of Internet, Intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Compliance with Section 508 of the Rehabilitation Act of 1973 | 228 |
| MR035 | The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) are retained and/or accessible according to the federal requirements in 45 Code of Federal Regulations (CFR) Part 75 and/or applicable State and/or federal requirements. | Data Retention and Accessibility | Will Meet | Attachment D - Mandatory Requirements | Data retention and accessibility | 228 |
| MR036 | The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications. | Staffing | Will Meet | Attachment D - Mandatory Requirements | Approval for all key staff hired and personnel assigned | 229 |
| MR037 | The Vendor must employ Key Staff assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within 30 calendar days of the contract award. | Staffing | Will Meet | Attachment D - Mandatory Requirements | Key staff employment requirements | 229 |
| MR038 | The Vendor must provide the Department a minimum of ten (10) business days' notice for staffing changes. | Staffing | Will Meet | Attachment D - Mandatory Requirements | Notice of staffing changes | 229 |
| MR039 | The Vendor must replace key staff within 30 business days after the position is vacant, unless a longer period is approved by the Department. | Staffing | Will Meet | Attachment D - Mandatory Requirements | Replacement of key staff within 30 business days | 229 |
| MR040 | The Department has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Department determines that any such staff has interfered or may interfere with the Department's interests identified above. | Staffing | Will Meet | Attachment D - Mandatory Requirements | Ensuring operations are efficient, professional, legal, and secure | 230 |
| MR041 | The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with Vendor on the project. | Staffing | Will Meet | Attachment D - Mandatory Requirements | Financial, legal, ethical, and all other forms of responsibility | 230 |
| MR042 | The Vendor must have controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. Personal information data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Administration (SSA) data (including, but not limited to, family, friends, and acquaintance information). | Security | Will Meet | Attachment D - Mandatory Requirements | Accessing, editing, or sharing personal information controls | 230 - 231 |
| MR043 | The Vendor must ensure that all project staff have completed a Department Office of Management Systems (OMIS) Vendor Employee Confidentiality Statement (VECS) before beginning work on the project. | Security | Will Meet | Attachment D - Mandatory Requirements | Vendor employee confidentiality statement | 231 - 232 |
| MR044 | The Vendor must comply with Federal Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Federal Executive Order 11246 | 232 |
| MR045 | The Vendor must provide a drug free workplace for employees and all applicable agents, including, but not limited to, subcontractors. All agents of the Vendor must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract. | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Drug-free workplace | 232 - 233 |
| MR046 | The Vendor must designate one named individual in its proposal as the Vendor Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance officer. | Security | Will Meet | Attachment D - Mandatory Requirements | HIPAA compliance officer | 233 |

| Mandatory Requirements | | | | Vendor Response | | |
|---|---|---|---|---|---|---|
| Req ID # | Requirement Text | Type | Vendor's Disposition | Attachment | Section | Page # |
| MR047 | The Vendor must not publish or copyright any data using the Department's name without prior written approval by the Department for every instance.<br>In this context, "data" shall mean all results, technical information and materials developed and/or obtained in the performance of the services hereunder, including but not limited to: all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder. Except with respect to any commercial software, the Department will be and remain the owner of all data provided to the Department by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records. | Publication and Copyright of State Data | Will Meet | Attachment D - Mandatory Requirements | Approval for use of the Department's name | 233 |
| MR048 | The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs. | Cost of Maintaining Access to State Systems | Will Meet | Attachment D - Mandatory Requirements | Expenses required to access department systems | 234 |
| MR049 | The Vendor must make available to the Department the results of any third-party audit conducted, including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization. | Audit Compliance | Will Meet | Attachment D - Mandatory Requirements | Availability of third-party audit results | 234 |
| MR050 | The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract. | CMS RFP Checklist | Will Meet | Attachment D - Mandatory Requirements | Authorization to access records | 234 |
| MR051 | The Vendor should administer a prior authorization program in accordance with applicable law and Appendix 3: Service Provider Agreement. This includes, but is not limited to, United States Code 42 CFR § 438.210, West Virginia Code §33-25A-8s, and requirements for parity in mental health and substance use disorder benefits in 42 CFR § 438.910(d). | Federal and State Requirements | Will Meet | Attachment D - Mandatory Requirements | Administration of a Prior Authorization Program | 234 - 236 |

# Department of Health and Human Resources

## ATTACHMENT E: DETAILED SPECIFICATIONS APPROACH

Instructions: In this response template, the Vendor should provide a narrative overview of how its proposed approach will meet the detailed specifications by subject matter area (located in Column D of *Appendix 1: Detailed Specifications*). Responses should reference specifications using the appropriate IDs (located in Column A: Spec ID # in *Appendix 1: Detailed Specifications*). The Department also expects the Vendor to propose its approach for meeting any narrative included in *Section 4: Project Specifications* of this RFP.

Additional guidance for completing this attachment's response template is as follows:

1. The Vendor should refer to Column C: Vendor Response Guidance in *Appendix 1: Detailed Specifications* for information requested in the Vendor response to each specification. The Vendor is not limited to providing only the information requested in this column.
2. Responses should be focused on the business processes and specifications and not just provide generic or marketing descriptions of Vendor qualifications.
3. A statement of compliance or intent to perform the specification will not be considered a narrative description or explanation, and may negatively affect the Vendor's score if given when a narrative description or explanation was requested.
4. The Vendor is not required to address each specification independently and may combine responses to specifications, particularly if a more comprehensive response helps the Vendor convey its approach. However, the Vendor should cite where each specification is addressed within the narrative for traceability (using the appropriate IDs) and provide a level of detail that enables the Department to evaluate the response at the individual specification level. The figure below provides an example of the expected format.

**Figure 2: Example of Expected Specification Response Format**

1. BENEFIT ADMINISTRATION

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Benefit Administration below. The Vendor's narrative response should not exceed 80 pages.

| | | |
|---|---|---|
| BA01 | The Vendor should establish a process to implement authorization criteria and a process for providers to request authorizations for socially necessary services (SNS). | The Vendor should provide a proposed process to administer authorization criteria for these services in accordance with Appendix 9 SNS Utilization Management Guide. |

5. If the Vendor identifies materials that help support or demonstrate its narrative response (e.g., process flows, samples, templates, figures, or tables), the Vendor should include and explain these materials within the response template.

# Department of Health and Human Resources

## 1. Benefit Administration

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Benefit Administration below. The Vendor's narrative response should not exceed 80 pages.

## 2. Care Management

The Vendor should refer to the relevant specifications located in *Appendix 1: Detailed Specifications* (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in *Section 4: Project Specifications* in this RFP, and then describe its approach to Care Management below. The Vendor's narrative response should not exceed 60 pages.

## 3. Community/Stakeholder Engagement

The Vendor should refer to the relevant specifications located in *Appendix 1: Detailed Specifications* (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in *Section 4: Project Specifications* in this RFP, and then describe its approach to Community/Stakeholder Engagement below. The Vendor's narrative response should not exceed 25 pages.

## 4. Member Services

The Vendor should refer to the relevant specifications located in *Appendix 1: Detailed Specifications* (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in *Section 4: Project Specifications* in this RFP, and then describe its approach to Member Services below. The Vendor's narrative response should not exceed 35 pages.

## 5. Network Development

The Vendor should refer to the relevant specifications located in *Appendix 1: Detailed Specifications* (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in *Section 4: Project Specifications* in this RFP, and then describe its approach to Network Development below. The Vendor's narrative response should not exceed 25 pages.

## 6. Provider Services

The Vendor should refer to the relevant specifications located in *Appendix 1: Detailed Specifications* (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in *Section 4:*

*Project Specifications* in this RFP, and then describe its approach to Provider Services below. The Vendor's narrative response should not exceed 25 pages.

## 7. QUALITY

The Vendor should refer to the business specifications located in *Appendix 1: Detailed Specifications* (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in *Section 4: Project Specifications* in this RFP, and then describe its approach to Quality below. The Vendor's narrative response should not exceed 60 pages.

## 8. VALUE-ADDED SERVICES

In addition to the above subject matter areas from *Appendix 1: Detailed Specifications*, the Vendor should include any Value-Added Services to be offered in this section, as well as any eligibility requirements and potential limits for these services. Vendors are not required to propose value-added benefits, but inclusion of such services may impact the Vendor's overall evaluation. The Vendor's narrative response should not exceed 5 pages.

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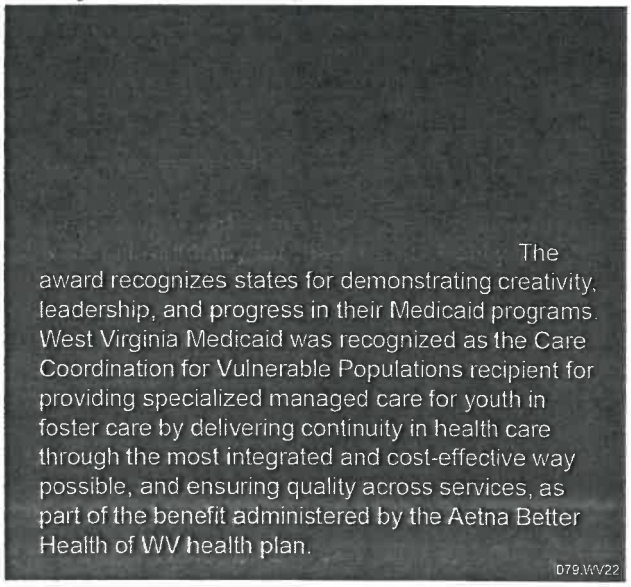
## 1. Benefit Administration

**The Vendor should refer to the relevant specifications located in Appendix 1: Detailed Specifications (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in Section 4: Project Specifications in this RFP, and then describe its approach to Benefit Administration below. The Vendor's narrative response should not exceed 80 pages**

Since the inception of the Mountain Health Promise foster care program in March 2020, Aetna Better Health of West Virginia (Aetna) has demonstrated our commitment and ability to manage the care for some of West Virginia's most vulnerable citizens. Leveraging our unmatched experience in the state, our approach to benefits administration incorporates:

**Meaningful collaboration across all state agencies.** Aetna has prioritized establishing true partnerships and collaborations across all state agencies so that we can tailor the solutions we offer to the true needs of the child welfare system. Through our many collaborations, our local staff has been able to, for example:



The award recognizes states for demonstrating creativity, leadership, and progress in their Medicaid programs. West Virginia Medicaid was recognized as the Care Coordination for Vulnerable Populations recipient for providing specialized managed care for youth in foster care by delivering continuity in health care through the most integrated and cost-effective way possible, and ensuring quality across services, as part of the benefit administered by the Aetna Better Health of WV health plan.

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- **Support the State to achieve Department of Justice (DOJ) goals.** We are supporting the State in achieving the goals established by the DOJ by collaborating closely with our State partners to reduce out-of-state placements and the number of children in care, using a data-driven approach that addresses the root causes of this action. Aetna has tailored our interventions to advance the DOJ's goals through activities that include implementation of the Children and Adolescent Functional Assessment Scale (CAFAS). Our approach ensures proper assessment and placement for all members; helps to make certain that all children in residential mental health treatment facilities (RMHTFs) are properly assessed; and confirms that decisions made are evidence-based and data-driven. **Between February 2020 and August 2022, total residential placements decreased by 10.8%.** In-state residential placements decreased by 9.76% and out-of-state residential placements decreased by 25.73%. In collaboration with BSS and providers, we have also reduced the number of youths in group RMHTFs from 821 in March 2020 to 662 as of October 2022, which is below the DOJ goal of 689 by December 31, 2022.
- **Address workforce and staffing shortages**. Our efforts have augmented State agency capacity across West Virginia. For example, we are addressing a workforce issue with the Bureau of Social Services (BSS) in eastern West Virginia. In that instance, our judicial administrator (part of our Care Advocate Team) supplements existing resources in the circuit court to ensure appropriate follow-through and communication between the court and BSS. In addition, efforts by our regionally based Care Coordination Teams often help alleviate the workload of Agency caseworkers to allow heightened focus on the child and family.
- **Partner to hold providers accountable.** Through ongoing and recurring utilization management reviews to confirm appropriate use (e.g., medical necessity, adherence to parity, evidence-based standards of care), cross-functional fraud, waste, and abuse monitoring, and local provider oversight

efforts – we have demonstrated that we are a responsible steward of the State. For example, **through ongoing utilization management monitoring and fraud, waste, and abuse prevention, we had over $2.3M in savings in 2021, and close to $2M thus far in 2022.**

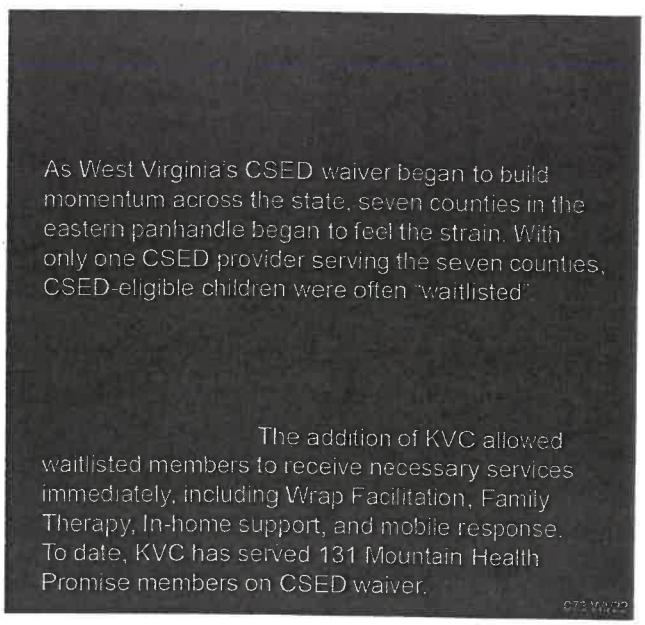
- **Local, West Virginia-based staff.** Close to 90% of Aetna employees who support Mountain Health Promise reside in the state, far exceeding our contractual residency requirement. This commitment to a local presence is reflected in our:
- **Care Connection Team (CCT) model.** Our care managers live in the areas of their assigned members, which facilitates consistent and ongoing oversight and engagement of the children, youth, and families we manage care for. Through our highly local model, care managers regularly outreach to members and caregivers face-to-face, bringing a strong understanding of the community's resources, strengths, and challenges to their care planning approach.
- **Leadership with West Virginia child welfare experience.** Our leadership team brings 400 years of extensive knowledge and experience working with West Virginia's child-serving system of care and the children and youth served by the Mountain Health Promise Program.
- **Presence in provider, stakeholder, and State agency offices.** Through onsite meetings and community-based collaborative efforts, Aetna staff have become trusted partners in the State. We will continue to build upon the relationships we have established throughout the State, by attending (upon invitation) the BSS Multidisciplinary Team (MDT) meetings; conducting onsite visits with BSS staff; and more. **We have attended over 6,300 MDT and health plan inter-disciplinary care team meetings since April 2020, including 447 RMHTF facility meetings.**

**Innovations tailored to Mountain Health Promise.** Aetna continually seeks to enhance and improve our approach to managing care for Mountain Health Promise members by implementing innovative models, processes, and resources that impact members, providers, and the State.

- **Innovations in approach to managing care for members in foster care.** Through recurring stakeholder, member, and provider outreach and collaboration – combined with evidence-based best practices leveraged from our national experience serving children in the child welfare system – we have developed and implemented innovative foster care models of care. For example, our **Promise Project** incorporates an individual member review process completed in an emergent fashion (within 24 hours of request), to assist and support the Agency with placement disruptions, unnecessary lengths of stay, and discharge planning support to reduce the number of youths in out-of-state and residential care. Through these efforts, we have been able to proactively prevent placement disruptions through close oversight and connection to the children we serve and collaboration across the system of care. **We have conducted 200 special reviews in the first nine months of 2022 to assess level of care, the potential to move to a lower level of care, and other service needs.**
- **Provider services and network innovations.** We are continually implementing targeted and innovative ways to increase provider satisfaction while increasing members' access to high-quality care. Our **pilot program with KidLink Treatment Services** allows us to cover services provided by providers who are not enrolled in West Virginia Medicaid. This program allows payment to go to these providers through KidLink to increase member access to dental, vision, and other preventive care. In addition, our collaboration with Highland-Clarksburg Hospital, we enhanced their rate to support a high-acuity member through the provision of additional personnel, thus allowing the member to remain in state for care. **In our 2021 provider satisfaction survey, 86% of respondents expressed overall satisfaction with Aetna.**

- **Member-centric innovations.** As described throughout our response, Aetna offers members and families a highly individualized approach to care. In practice, this takes many forms, spanning population health solutions that impact the entire membership and community to personalized solutions designed for the specific member. For example:
  - We ensure access to medication for members transitioning between facilities by connecting the prescribing physician to the pharmacy to confirm prescriptions are received and authorized for the member.
  - We deploy specialized transportation solutions, in partnership with BSS, to ensure members have access to the best care to meet their needs, in a manner that is least disruptive. We arranged for a medical transport flight for a member needing out-of-state care to prevent exacerbation of the member's behavioral health issues. In another instance, we arranged for an ambulance trip to transport a member to a residential care facility in Utah when medical flights providers were unable to provide transportation.
- **Technological innovations that advance coordination of care.** Aetna brings national Medicaid experience, best practices, and technological innovations to West Virginia. For example, we are enhancing FamilyConnect, our proprietary, innovative solution that supports seamless coordination of care by making key information available to all authorized individuals in a member's care team. FamilyConnect securely stores and provides real-time access to members' assessments; care plans; authorizations; admission, discharge, transfer (ADT) data; community resources and Social Determinant of Health (SDoH) referrals; claims; and medications. **To support and facilitate continuity of care, FamilyConnect 2.0 will be implemented by Q4 2022 with progressive enhancements through July 2023.** FamilyConnect 2.0 will act as the single source of information to provide alignment in services and goals for physical health, behavioral health, and socially necessary services. With a member's consent, authorized users–including providers and the care team–will be able to access FamilyConnect 2.0 to share information and collaborate to improve the member's care and wellness journey.
- **Flexible and agile approach to managing care.** Throughout our tenure in West Virginia and multiple other states, we have demonstrated our ability to take on new populations and additional covered services. As an organization, we are nimble, seamlessly adapting to the needs of the populations we serve. We readily pivot our solutions to address conditions and needs that are most prevalent in the population, and we are uniquely positioned to do this based on our experience in the state as illustrated by the following examples:

- **Targeted capacity building initiative.** We were able to re-invest money into supporting the development and expansion of much-needed intensive community-based services and in-state residential programs. This initiative includes targeting specialized populations; expansion into community-based services such as Children with Serious Emotional Disorder (CSED) waiver, especially in underserved areas; and SDoH.
- **Agility during the Public Health Emergency.** During the COVID-19 pandemic, we quickly moved from in-person to virtual care options. We supported providers' expansion of teleservice delivery by supplying cameras/equipment to several provider organizations and developed training resources on the required place of service billing codes and procedures for timely claims payments. **Prior to the pandemic, only about 1% of services for our West Virginia Medicaid members were teleservices, but at the height of the pandemic, 16% were delivered via teleservice. Approximately 86% of teleservices were provided for behavioral health service needs and over 40% of teleservices were delivered to members in rural locations.**




## Care coordination

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| BA31 | The Vendor should use information systems to identify members with special needs and to isolate data specific to eligibility category or diagnosis.<br>The Vendor should describe how it will meet this specification. |
| BA03 | The Vendor should support the Agency caseworker in identifying the needs of the family and assist in developing case plans to meet those needs in the least restrictive manner.<br>The Vendor should describe the procedures and protocols for how it will meet this specification. |
| BA09 | The Vendor should assist in scheduling/rescheduling appointments, providing appointment reminders, and removing potential barriers to care, including, but not limited to, transportation.<br>1) The Vendor should describe how it will work with caregivers and families to meet this specification.<br>2) The Vendor should give an example of a barrier to care and how the Vendor would work to remove it. The Vendor may use transportation for this example but is not required to do so. |

Aetna uses a person-centered, data-driven approach to identify, assess, and respond to the special physical, behavioral, and social needs of Mountain Health Promise members. Leveraging the Aetna's national best practices, and in accordance with the Model Purchase of Service Provider Agreement (SPA), we created a care coordinator model that assigns each member a specialized care coordinator who provides the member with individualized support and coordinates the member's integrated services to address their holistic needs. We will continue to use our proprietary stratification tools, such as the Consolidated Outreach and Risk Evaluation (CORE™ 2.0) models, to timely identify member need.

## Using information systems to identify members with special needs [BA31]

Aetna understands that all children and youth in the child welfare system have experiences that put them at risk for special physical, behavioral, and social health care needs because of their past and

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current environments, including foster care, adoption, justice-involved, and more. These children experience frequent placement changes, adverse childhood experiences, and neglect. To deliver seamless access to services and trauma-informed care, each Mountain Health Promise member is assigned a care coordinator, regardless of the care management tier they are assigned to.

We use many data sources to identify and assess members, and to assign them to a level of care coordination that meets their needs (e.g., wellness and prevention, management of chronic conditions, complex care management). As further detailed in our responses to CM01, CM09, and CM17, in addition to using information systems, we implement a multi-faceted approach to identifying children and youth with special needs that incorporates:

- Review of multiple data sources
- Provider, stakeholder, member/family, and care manager referral
- Timely screenings and comprehensive and targeted assessments

On an ongoing basis, we closely monitor children and youth with special needs to ensure their needs are consistently met. We conduct monthly meetings with DHHR focused solely on the special health care needs of children and youth in the Mountain Health Promise program. During these longstanding meetings, we collaborate with DHHR to review the services and supports for our children and youth with special needs to identify additional members in need of specialized services.

Key information systems used to identify children and youth with special needs include:

- **Enrollment file:** Our enrollment manager application loads/processes/generates data from the enrollment file automatically end-to-end (i.e., member data received via the State 834-eligibility file, coordination of benefits/third-party liability records, and enrollment load reports for verification of data load). This data contributes to identification of children and youth with special needs and can inform care coordinators about member diagnoses and participation in West Virginia child welfare programs.
- **Screening and assessment process**: Aetna uses our initial and comprehensive screening and assessment process to identify new children and youth who have special needs but were not identified as such on the enrollment file. We screen all members within 30 calendar days of the date of identification. As further detailed in Section 2, care management, we use several pieces of key information to complete our screening and assessments to inform our 360-view of the member. Completed screenings and assessments are available to the care team, as appropriate, in our electronic health record FamilyConnect 2.0.
- **Data analysis**: Our care coordinators conduct a stratification analysis to identify high-risk members. We use integrated information management tools, including data from our proprietary CORE 2.0™ predictive modeling platform (for members with prior utilization) and our electronic population health management platform, to identify indicators of member needs. Aetna's care management team reviews claim-specific information to identify capitated services; diagnosis and condition; physical, behavioral health, and social risk needs; use of DME; and more that indicate the member has a priority condition.
- **Real-time coordination of care**: Aetna's UM teams track the inpatient census daily. Our care coordinators receive automatic notifications for inpatient admission alerts, and we also identify members with multiple inpatient admissions or ER visits. Our Interdisciplinary Team (IDT), consisting of medical directors; the chief medical officer (CMO), physical/behavioral health care team members; a pharmacist; the socially necessary services (SNS) liaison; and representatives from UM, care

management, and discharge planning **convenes weekly** to discuss children and youth with special needs. Decisions are made as a group on the best approach to take with these members (e.g., what potential behavioral health needs can be addressed, SNS needs, potential discharge planning needs such as home modifications and DME). Expedited meetings are scheduled, as needed, for members experiencing a PH or behavioral health crisis.

- **Predictive modeling for opioid use disorder (OUD)**: We utilize advanced analytics to identify members at high risk of OUD. Data sources include eligibility data, medical claims data, pharmacy claim data, approved diagnosis codes, procedure codes, and drug codes. Using this data, a multivariate logistic regression model was developed to assess the likelihood of a member developing OUD using person-level data. Our final model includes the following variables: age (e.g., 0-18 years, 19-29 years, etc.), rate group, ethnicity, chronic pain, alcohol abuse, tobacco abuse, first opioid prescription lasting more than seven days, opioid days' supply, and unnecessary or frequent ER visits. All factors have been demonstrated to be statistically significant. The model accuracy of prediction is 89% and high-risk members with OUD are flagged by a selected cutoff value, so that our pharmacy and CCTs can limit harm of use and collaborate regarding outreach strategies to the member. Using these analyses, we have implemented interventions that include point-of-service edits and coverage of naloxone (Narcan) without prior authorization.
- **Pharmacy data usage:** Aetna monitors and analyzes the pharmacy usage data file to identify children with special health care needs and to prioritize outreaching to them for assessment. Our care coordinators incorporate medications into members' care plans and flag potential over-utilization and under-utilization of prescribed medications.

### Eligibility and outreach to children with special needs

On a monthly basis, Aetna care coordinators outreach children and youth who have special health care needs. Aetna care coordinators help them access of Aetna's specialty care program which provides care management and access to specialty services through a system of outreach specialty clinics, thus enabling children with special health care needs to receive a member/family-centered medical home approach to comprehensive, coordinated services and supports. Members identified with special healthcare needs will be referred to specified providers who have been deemed to have the necessary training in meeting the member's unique needs.

**Eligibility is based on the following factors:**

- Must be a U.S. citizen
- The child must be under 21 years of age
- The child must reside within West Virginia
- The child must have an eligible medical diagnosis

**Medical conditions that are eligible include, but are not limited to, the following:**

- Conditions which involve bones, joints, or muscles
- Heart conditions
- Epilepsy and other convulsive conditions
- Neurological conditions such as cerebral palsy and spina bifida
- NAS
- Certain operable eye conditions, such as crossed eyes and congenital cataracts

- Kidney and urological conditions, including those requiring dialysis
- Cleft lip/palate and other conditions requiring treatment by an otolaryngologist
- Ear, nose, and throat conditions requiring treatment by an otolaryngologist
- Hearing loss, including hearing aid placement, and related services
- Other chronic conditions, such as: cystic fibrosis, and sickle cell anemia

**All children and youth in the Mountain Health Promise are assigned an Aetna care coordinator who acts as the convener and single point of contact for the member and the member's care coordination team (CCT).**

## Focus on SDoH

As detailed in our response to Attachment E.2, care management, Aetna's CCT and care advocate team (CAT) support and complement each other to address SDoH needs of all members.

- **Regional CCTs** focus on the direct needs of Mountain Health Promise members, acting as the hub for coordination of continuity of care for members. CCTs leverage our Community Resource Directory (CRD), which includes 4,700 local West Virginia social service resources, to identify and connect families to both local and national available resources. Aetna care coordinators conduct follow-up within 30 days to close the resource loop for non-emergent needs and 24 hours for emergent needs that could impact the immediate health and safety of the member or their family.
- **Our CAT** was created to address the population level needs of *West Virginians* and helps our CCT mitigate external factors that negatively impact health in West Virginia. The CAT collaborates with providers and community stakeholders to develop statewide, community, and plan-based services to reduce barriers and improve access to services and supports.
- **Our Better Together: SDoH Solutions Team** is a key partner to the CCT and CAT, supporting these teams to ensure resource needs can be met. We know it is not enough to just make community resource referrals, we must guarantee community-based agencies have capacity to meet member needs. Our SDoH Solutions Team establishes partnerships across the state and implements innovative solutions to address identified gaps, such as housing, food instability, employment, and education. This team is led by our Manager of SDoH and Community Partnerships Jordan Pruett who is a West Virginia native and has worked in community development with Aetna for 10 years.

## Supporting the agency caseworker to identify family needs [BA03]

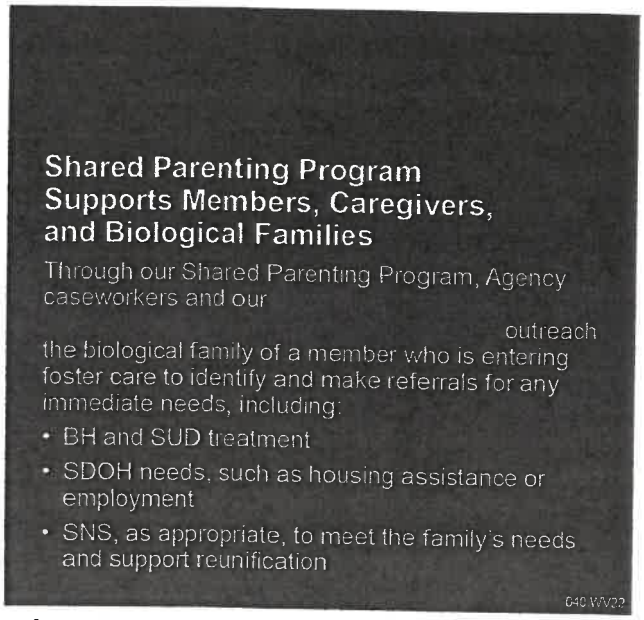
We know that children and youth involved in the child welfare system are among the most vulnerable for poor health outcomes, both physically and behaviorally. We strive to close gaps in care caused by frequent placement changes, fragmented care, and neglect through seamless support services and trauma-informed care.

Just like so many other sectors of the American economy today, staffing shortages within the child welfare system have impacted states' abilities to meet the needs of some of their most vulnerable residents. West Virginia is experiencing child welfare workforce shortages around 30%, according to recent reports by the DHHR's Bureau of Social Services (BSS). Through the Mountain Health Promise plan, Aetna supplements the State's programs and caseworkers by deploying our wraparound-informed model. As discussed in Section 2, care management (CM23), Aetna CCTs are currently embedded in several BSS offices, not only providing real-time staff support, but also improving communication and

collaboration to fully support the family's full spectrum of need. Aetna's care management team and Kepro's (vendor authorizing and reviewing SNS) team collaborate with the Agency caseworker, using wraparound standards of care, in identifying services available for a full continuum of medical, behavioral, and SNS support based upon the identified needs of the child.

### Supporting agency staff

Aetna care coordinators partner with Agency caseworkers through attending in-person MDT meetings (after invitation from the Agency caseworker), and telephonic and email contact as needed to address a member's/family's needs. Beginning with the initial outreach, this interdisciplinary, whole-person approach helps to identify, support, and address the member's needs for safe family relationships, access to normative experiences, and continuity of health, mental health, and dental services.




The care coordinator's goal is to avoid duplication and/or disruption of existing services and provider relationships through the collaborative development of the member's Individual Service Plan (ISP) that carefully aligns services. The individualized, whole-person plan includes specific interventions or tasks for the Agency caseworker and Aetna care coordinator to help the member achieve their plan, such as recommendations, assisting the member with access to a provider or a community resource, or following up to verify the member received the care or services needed. The ISP also includes self-management goals to engage the member in their own health and well-being. The team identifies caregivers who need further reminders of appointments or assistance in scheduling or getting children to their health care visits. To support the caseworker, Aetna includes peer support specialists and Community Health Workers (CHWs) on all CCTs. CHWs can serve to both remind caregivers of appointments and assist with scheduling and rescheduling appointments.

### Wraparound-informed strategies

In West Virginia, we employ wraparound-informed strategies to build constructive relationships and support community-based, culturally relevant, family-centered services for children with emotional or behavioral concerns and their families. Care plans are comprehensive and co-created by caregivers, community supports, and professionals. They focus on members' strengths and include member and family voice whenever possible. They address multiple life domains across home, school, and community, including living environment, basic needs, safety, and social, emotional, educational, spiritual, and cultural needs among others. Through our wraparound model and other programs including Charting of the LifeCourse Framework, Safe at Home, and Family Finding (discussed in Section 2, care management), BSS caseworkers can rely on and participate in an interdisciplinary care team that addresses the specific needs of each child and family they work with. Our CCTs work closely with case managers on a regional basis, living and working in the communities they serve and acting as the center of all care coordination for a member's continuum of care. Aetna's high standards for CCT

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training, credentialing, and staffing ratios, along with existing relationships with key stakeholders, help build community connections to support child safety and health goals.

### First in Care program

Our First in Care program promotes early and ongoing collaboration between the Agency's case workers and Aetna. An Agency caseworker notifies an Aetna Crisis Intervention Specialist within 24 hours of a member being removed from their biological home. This early identification allows our Crisis Intervention Specialist to outreach and engage the member's new caregiver, to work on obtaining medical records, immunization history, medication history and current medication. We also identify and address any immediate needs the new caregiver has, such as bedding, car seats, clothing, school supplies, and more.

Our care managers use the Health Risk Assessment (HRA) screening tools to identify whether a child currently has or is at risk of developing any gaps in care or health conditions that require clinical intervention. Along with the HRA, we also complete a Health Equity Contact Event (HCE) to determine any SDoH that acts as a barrier to accessing care, which could include housing, transportation, childcare, or food insecurity, prompting additional resources to be included in the person-centered plan of care. Members determined to have socially or medically complex needs (e.g., multiple chronic conditions, SDoH barriers, gaps in care, health disparities, etc.), receive a comprehensive evaluation from our CCT and are supported at an appropriate intensity based upon identified needs and defined criteria. These assessments are done initially and then annually or upon any changes in condition or SDoH to update the care plan accordingly. Physical health, behavioral health, and SDoH needs are all incorporated into the member's care plan.

We share the care plan with the member's PCP, current caregiver, or residential treatment provider. Our team works directly with caregivers including foster placement and BSS caseworkers to support the member and reach the goals of the care plan. We ensure proper connection to services, help identify immediate needs, schedule appointments for both medical and behavioral health needs, and connect members to community supports.

### Shared Parenting program

Another part of our wraparound-informed model is the Shared Parenting Program, which purposefully engages the biological family in their child's care provisions while in placement, as appropriate. Family members receive support from a Family Peer Support specialist with lived experience and Agency caseworkers who engage the family to identify urgent needs and make appropriate referrals to help them be successful.

### Trauma-informed care training

Trauma-informed care training (TIC) training is provided for providers and stakeholders including all SNS workers. This includes understanding the use of

#### Supporting the Agency During Staffing Shortage

The Deputy Commissioner requested Aetna Better Health's assistance in Berkeley County, where county judges raised concerns that children weren't receiving timely referrals assistance with needed resources. In collaboration with DHHR, we conducted a 90-day action items plan to resolve the issues.

**Our Care Management Team:**

- Conducted weekly visits to the DHHR offices
- Attended all MDT meetings, and provided DHHR with detailed post-meeting notes and action items
- Hosted weekly debriefings to make sure all of the children's' needs were met

**Our Legal System of Care Team:**

- Attended hearings weekly to help children and youth transition to Mountain Health Promise
- Provided the DHHR supervisor with daily action items from the court hearings
- Conducted weekly meetings with key BSS staff to discuss any outstanding issues

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assessments (such as Adverse Childhood Experiences ACEs), as well as appropriate interaction with members who have or are experiencing trauma. This is especially important when creating care plans and health goals.

## Appointment scheduling, reminders, and transportation [BA09]

Upon completion of the assessment process described above, and as early as possible, Aetna care coordinators proactively identify potential obstacles to care and establish strategies with the caregiver to minimize potential missed appointments (e.g., addressing issues related to transportation, access to a reliable phone, childcare, etc.). Aetna care coordinators use a hands-on approach to mitigate obstacles, assisting with appointment scheduling and resolving any barriers to getting to the appointment, such as transportation. Specifically, to assist children and youth to reach needed appointments, we offer **NEMT** through coordination with Modivcare, the State's vendor. We also help coordinate childcare and will reschedule appointments that the member or their family is unable to attend.

CCT staff enter reminders in FamilyConnect (see Figure E.1-1) regarding required appointments that are coming due, as well as reminders regarding scheduled appointment dates.

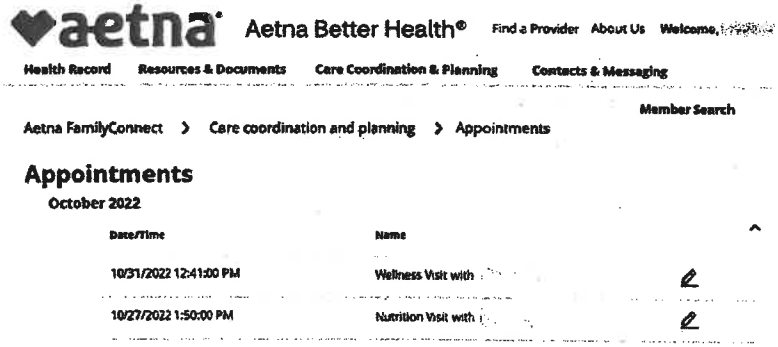


**Figure E.1-1: FamilyConnect Appointment Screen**
Supports CCT Appointment Reminder and Scheduling Efforts

The care coordinator also works with the member's providers to identify immediate gaps in care and unaddressed needs. For example, we collaborate with the West Virginia Primary Care Association to ensure that PCPs understand the importance of informing the CCT when a member has missed an appointment. If the member cannot continue with an established care provider, the care coordinator will assist the member in requesting the transfer of records and make sure the new provider addresses member needs.

**Provider Support to mitigate Missed Appointments.** As a part of PCPs' training, we include information on solutions to improve member participation and reduce no-show/missed appointments. These strategies include working with the member's Aetna care coordinator, provider outreach to the member and their caregivers, and provider support tools to assist with resolving members' barriers to care. **In 2023, under our new Provider Optimization Delivery (POD) model, provider support representatives, provider operations coordinators, claim analyst, and quality practice advisors will be available to assist providers struggling to conduct appropriate EPSDT screenings and address gaps in care.**

### Example of removing barrier to care

Through our ongoing monitoring of gaps in care, our care management team identified several members in rural areas of West Virginia who were missing or behind on well-child visits and recommended immunizations. Care coordinators immediately conducted outreach to the members and discovered lack of transportation was a major barrier in rural areas where members frequently had to travel farther distances to see their provider. Our care management team collaborated with the network development team to identify local school-based health centers (SBHC) and rural health clinics (RHCs) in the area who could provide EPSDT services for members at school or at nearby locations. Care

coordination worked with members to locate the most convenient clinic and assisted members with scheduling appointments to close the gaps in care. **As a result, Aetna was able to facilitate increased access to care.** We have also **demonstrated year over year percentage improvements on all EPSDT services.** Please see our response to Attachment E.2 provider services response for additional details.

## Maternity, prenatal and infant care, and family planning

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| BA30 | The Vendor should identify pregnant women at enrollment and on an ongoing basis. The Vendor should promote "early and often" prenatal care for women who are identified as being pregnant, for populations eligible for medical services. The Vendor should also identify high-risk pregnancies and immediately enroll the member into care management.<br>1) The Vendor should describe the mechanisms it will employ to identify pregnant women, both at enrollment and on an ongoing basis.<br>2) The Vendor should describe how it promotes "early and often" prenatal care for women.<br>3) The Vendor should describe what methods it will use to identify high-risk pregnancies and enroll them into care management. |
| BA38 | The vendor should establish a process to reconcile all newborn enrollments to ensure that enrollments are back dated to the first day of the month of the newborn's birth month.<br>The vendor should describe the process of identifying newborn enrollments that do not have the correct eligibility date and a process to communicate that information to BMS for review. |
| BA28 | The Vendor should inform members of their choices in Family Planning services, for populations eligible for medical services. Per Appendix 3: Service Provider Agreement (SPA), Family Planning services are defined as: services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy.<br>Information on the West Virginia Family Planning Program can be found at the following link: https://www.wvdhhr.org/fp/<br>The Vendor should describe how it will meet this specification, including frequency and type of information provided by age and gender of populations that will receive the education. |

## Identifying pregnant members and promoting timely prenatal care [BA30]

Aetna uses a comprehensive approach to identifying pregnant members. We also regularly collect member demographic data to better understand the needs of the population, particularly the needs of women of childbearing age and those who are expecting.

Upon enrollment, we conduct an initial member assessment that includes a question to identify if a member is pregnant. If a member indicates they are pregnant during the initial assessment, our care coordinators conduct a more comprehensive assessment that screens each member for pregnancy risk factors such as pre-existing hypertension and diabetes as well as previous c-sections. Other methods include:

- Analysis of the enrollment file
- Care coordinators check the maternity notification system on a weekly basis to track all newly identified pregnant members
- Pregnancy Risk Screening Instrument (PRSI) form submissions
- Claims data and medical records
- Referrals from internal and external stakeholders

To incentivize early identification of members' pregnancies, we offer providers $20 for each PRSI they submit. An analysis of claims data shows 379 members have been or are pregnant.

Care coordinators outreach to 100% of individuals who have been identified as being pregnant to provide prenatal education, connect the member to prenatal care, and assess whether the member has new or exacerbated health care needs that would be better served in a different level of care management for members with higher acuity.




Aetna care managers receive a referral from our concurrent review nurses for any pregnant member that has a hospitalization not resulting in a delivery. We also have an onsite care management nurse at Charleston Area Medical Center's (CAMC) Women and Children's Hospital who meets with members, stresses the importance of prenatal care, and addresses gaps in care and any barriers to care such as transportation. We also have one embedded care coordinator at Marshall Health, and we are working with other high-risk OB providers to embed a care coordinator. We have certified lactation consultants who work with foster members, and we offer members a free breast pump without the need for prior authorization. Dr. Hembree, CMO, is a board-certified OB/GYN with 26 years of experience in West Virginia. As part of the CCT, we have regional OB Specialists to serve as consultants for other care coordinators so we can keep the single point of content for the member.

### Promoting early and often prenatal care

Since March 2020, Aetna helped manage care for 285 deliveries for the Mountain Health Promise program. We understand the critical importance of promoting **early and often prenatal care for every pregnant member**. We offer comprehensive, multimodal education and outreach strategies to make sure pregnant members obtain timely prenatal care.

Aetna provides information to members to promote a healthy pregnancy. Once we have identified a pregnant member, we encourage early and often prenatal care by scheduling an initial prenatal care visit within 14 calendar days of identifying the member's pregnancy.

All pregnant members receive our **"Healthy You, Healthy Baby" prenatal education book** which includes:

- Key contact information for Aetna care management, member services, 24/7 nurse line, and text4baby




**Figure E.1-2: Aetna's "Healthy You, Healthy Baby" Book**
Provides information about the importance of prenatal care

- Information on timely prenatal and postpartum visits
- Healthy eating and exercise tips
- Resources for members with alcohol, tobacco, and substance use issues
- Important EPSDT screenings and services once the baby is born
- Identify and address postpartum depression and how to reach Aetna, Help4WV, and other resources for support

The CCT can track and identify members who have a pattern of missing prenatal visits and will work with care coordinators who are assigned in near-real time to resolve barriers to care. Our regional CCTs stay in close communication with their community providers and participate in multidisciplinary case rounds to review members with a pattern of missed visits as well.

In addition to outreach to schedule an initial prenatal care visit and to provide educational materials, Aetna implements a comprehensive maternal and pregnancy program.

**Our Maternity Matters program** is a preventive health program for pregnant members and new mothers that aims to support healthy prenatal and postnatal behaviors while reducing the incidence of premature births. Our Maternity Matters program supports all members and unique their pregnancy journey, recognizing some foster care members reside with their babies in their foster homes while other members won't have the infant in their care.

Members can earn funds provided through a single reloadable Maternity Matters card and are available to use toward maternity and baby supplies, such as wipes, nursing supplies, diapers, and more. Members can receive a $50 incentive for completing their postpartum visit within 7 to 84 days after giving birth. As part of our Maternity Matters Program, we offer:

**Prenatal programs.** To support pregnant members throughout pregnancy and encourage early and often prenatal care, including:

- **Aetna-sponsored baby showers:** Care coordinators work with the Member Outreach department to invite members, families, and circles of support to regional Aetna sponsored baby showers, organized by local community-based organizations. In 2021-2022, we participated in 61 community baby showers. These baby showers provide low-income mothers-to-be and new mothers with baby supplies, education about the importance of prenatal care, and the ability to meet other pregnant members in the area. During the COVID-19 pandemic, we pivoted to drive-thru baby showers to offer continued support to pregnant and newly delivered members during the public health emergency. Our standard reward for participating mothers-to-be is a portable bassinet/playpen, which can be used to promote safe sleep for newborns.




- **Outbound text messaging, mailing, and social media:** Our educational text-messaging program consists of the Lifeline smartphone and targeted messages to remind members to get tests and screenings done. Through the text4baby program, routine reminders are sent to members to support

health goals related to prenatal and postpartum care, well-child visits, flu shots, weight management, diabetes, and substance use. We also use social media ads to educate our members on preventive measures, such as lead screenings.

- **Prenatal tobacco cessation:** Aetna care coordinators encourage pregnant members who smoke to participate in the State's Smoking Cessation program and assist them with quitting through the West Virginia Tobacco Quitline and the Tobacco-Free Pregnancy Initiative. This initiative educates pregnant members, as well as members of child-bearing age, about the dangers of using tobacco. In addition, we transfer any pregnant member who indicates she smokes when completing the health risk assessment to care management associates for education on smoking cessation through Krames' member health education materials. Aetna receives a list of our enrolled members accessing the Quitline and outreaches and enrolls them into care management if they are not already participating.

**Healthy delivery programs** to educate and incentivize members to adopt healthy behaviors and prepare for labor and delivery, including:

- **Moms and Babies program**: Pregnant members can receive a cribette or baby wrap carrier upon delivery and an educational toy on the baby's first birthday by enrolling in the Moms and Babies Program. To be eligible, pregnant members must be at 37 weeks gestation or more; experiencing SUD; or the member has delivered a baby born with Neonatal Abstinence Syndrome (NAS). Since March 1, 2020, we have provided 24 baby wrap carriers and 30 cribettes.

**Postpartum programs** that offer services and supports to members and their infants, including:

- **West Virginia Healthy Start/Helping Appalachian Parents and Infants (HAPI):** HAPI is administered by the OB/GYN Department at the West Virginia University School of Medicine and the West Virginia University Research Corporation. HAPI works with local agencies that employ Designated Care Coordinators (DCCs) (licensed professional social workers and registered nurses), in which provide education, resources and services to clients. HAPI services are targeted to improve maternal well-being during pregnancy, prenatal and postpartum care, and during the inter-conceptional period. It also offers services to fathers/male partners of HAPI clients. In each county where HAPI is offered, our care coordinators refer birthing parents to HAPI upon identification of their pregnancy.

## Focus on teen pregnancy

Aetna provides care to teens that are pregnant through care coordination co-located with three high risk obstetric providers in West Virginia. This team provides both physical care and case management. Together they offer education to the teen and her support system. Comprehensive assessments are conducted to determine not only the physical and behavioral health of the teen but also environmental, educational, social, and economic situations. These assessments set the foundation for additional necessary referrals such as the Regional Youth Service Centers for behavioral health needs, RMHTF, SNS, or other long-term housing.

> "We believe we have found a wonderful partnership with Aetna Better Health. Its staff is open, creative, and focused on finding positive solutions for West Virginia children and families. We look forward to continuing this positive relationship and helping our West Virginia families."
>
> *— Richard Royse, President and CEO, Crittenton Services, Inc.*

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Aetna collaborates with Crittenton Services, the only residential program in the state for pregnant teens or teen girls who are parenting. Crittenton leads West Virginia in providing trauma-informed care and behavioral health issues.

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To mitigate unplanned teen pregnancies, we were able to provide 26 Long-Acting Reversible Contraception (LARCs) to Mountain Health Promise members in 2021. The LARCs were inserted during the immediate post-partum period for proactive family planning. Aetna worked with providers to unbundle LARCs so hospitals would get reimbursed to increase the use of this type of contraception.

## Identifying high-risk pregnant members for engagement in care management

**Aetna uses a comprehensive approach to identifying high-risk pregnant members including:**

- Analysis of the enrollment file
- Screening and assessment process
- Provider incentives, including a $20 incentive payment for providers that complete a PRSI form and submit it to Aetna
- Communications between care coordinators and current members in foster care who become pregnant

All pregnant members are engaged in care management and those identified as high-risk will be risk stratified to Tier 3, complex care management. We automatically stratify pregnant members to complex care management if they currently have a high-risk pregnancy or a history of high-risk pregnancy, including but not limited to members currently using substances or with a history with substance use; and members who delivered an infant with NAS. **Complex care management has a staffing ratio of one care coordinator for every 17 members.** The smaller case load allows our care coordinators to provide higher levels of support to address the needs of high-risk members.




We provide our care management staff with specialized trainings for members. For example, "Our Baby Safe and Sound" program is a "train the member" model, allowing care coordinators to teach members, including high-risk members, about safe sleep habits for babies. Members also receive a special "this side up" onesie for participating in this program.

**Supporting mother and babies affected by NAS:** We support pregnant members at risk of delivering babies with NAS by co-locating a nurse care coordinator at Lily's Place, the first NAS center in the United States. Aetna was the first MCO to contract with Lily's Place in West Virginia. The care coordinator meets with the mothers face-to-face, enrolls them in care management, and follows them throughout pregnancy and concurrent treatment for SUD. Following birth, the baby is enrolled in care management and followed through the first year. The program helps keep the mother engaged in prenatal care and SUD treatment, and, most importantly, most babies remain with their birth mother. Aetna uses incentives to encourage participation in its NAS initiative such as receiving a portable bassinette/play pen or baby wrap carrier and an educational toy for completing the program.

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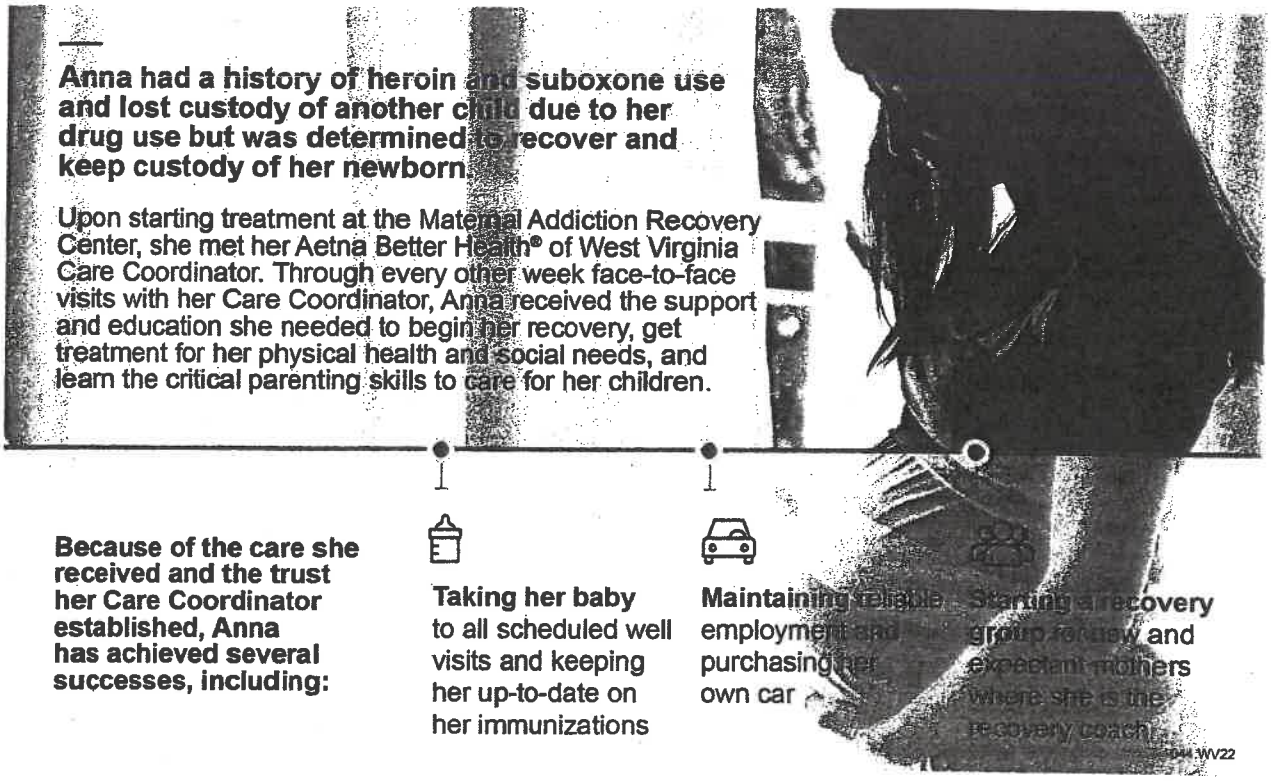


## Identifying newborns [BA38]

Aetna's newborn enrollment policies and processes include completing enrollment within 30 calendar days of the date of birth. Upon delivery, Aetna provides a temporary member ID to the newborn child. Through multiple outreaches, we confirm the baby's first and last name. The newborn's name and eligibility date are submitted to the State within 45 days. Newborn children of members are enrolled retroactively effective to the first day of the month of the newborn's birth month. These processes include transfer of newborn information to DHHR and notification of incorrect eligibility dates for BMS review. Aetna will provide all covered services to the newborn child during this time. Aetna will inform DHHR caseworker of the birth of an infant to a child in foster care within one business day of learning of the birth.

## Providing family planning services information to members [BA28]

Aetna provides **all members** with information about the types of family planning services available to them, their right to access these services in a timely and confidential manner, and their freedom to select their provider of choice. We educate members through:

- Our member handbook, which includes information on family planning and sexually transmitted infections
- Both female and male members receive information from their assigned care coordinator on family planning during the initial and comprehensive assessment process
- Krames educational materials on family planning

Additionally, CM staff reach out to all our new mothers to encourage them to discuss family planning and birth control options with their providers during postpartum appointments. Our care managers complete a postpartum assessment in our care management system that reviews family planning and reaches out to members with any gaps in care.

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The Aetna website contains a women's health section describing well-woman checkups, as well as pregnancy and family planning information. Members of all ages can access educational materials on a variety of family planning topics available in electronic and print formats, including the following:

- Birth control choices and types
- Understanding conception
- Tubal sterilization surgery
- Using a condom
- How birth control works
- Understanding vasectomy

### In-Person family planning education for members

We are committed to providing health education and counseling services to our members so they can make informed choices concerning contraceptive methods and are knowledgeable about the diagnosis and treatment of sexually transmitted diseases. Our care coordinators provide education in a culturally sensitive manner, including information on the LARC program and other forms of birth control. Our CCTs provide local resources for our providers and members, such as the West Virginia Adolescent Pregnancy Prevention Initiative (APPI), which provides statewide development, oversight, and coordination of adolescent pregnancy prevention activities. Each of our regional CCTs has a specialized OB care manager in every region to assist our high-risk members with access, care coordination, family planning education, and resources on all benefits, including LARC.

**In 2019, we expanded our local resources and now co-locate care management staff at high-risk OB/GYN offices and tertiary care facilities, including the Charleston Area Medical Center's Women and Children's Clinic and Marshall Obstetrics & Gynecology to provide education on LARCs and other forms of birth control face-to-face.**

To increase access to care, we are partnering with **Twentyeight Health** to offer members virtual access to family planning services, including home-delivered contraception and emergency contraception, testing for sexually transmitted infections, and more.

## Children with serious emotional disorder (CSED) waiver

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|---|---|
| BA39 | The vendor should describe its experience with administering and coordinating Children with Severe Emotional Disturbance (CSED) waiver type services to children and youth ages 3 up to 21 years, including, but not limited to, experience in West Virginia.<br>The Vendor should describe its experience, or the experience of their prospective subcontractors, with CSED waiver services. The Vendor should include any specialized programs, policies and processes that assisted their members to access these services. |

Aetna began administering the Children with Serious Emotional Disorder waiver (CSED) program on March 1, 2020. Two weeks later, the COVID-19 pandemic shut down health care operations as we knew them. To mitigate access to care challenges caused by provider staffing shortages, Aetna offered incentive monies to providers participating to expand CSED waiver services into additional counties (County expansion) and/or to offer additional CSED waiver services (service expansion). Additionally, we offered monies to agencies who were not participating in CSED waiver to come on board as CSED waiver providers. We added 12 new providers through this program, now totaling 26 state-wide.

**Winner of the 2022 KVC Values-Driven Partner Award**

In October 2022, KVC Health Systems presented Aetna Better Health of West Virginia the KVC Values-Driven Partner Award for showing that we share and live by one of KVC's core values, "Diverse perspectives are key to our progress." This award recognized Aetna Better Health's vision, partnership, and support in expanding family strengthening and mental health services to the eastern panhandle of West Virginia.

We also began offering monthly training dedicated to CSED waiver providers. The two-part training series focuses on CSED waiver Overview Training, which offers a solid foundational understanding of the waiver program, and Incident Management Process and Overview Training. **Aetna has presented 62 trainings to CSED waiver providers since March 2020.**

Also due to the pandemic, there had to be shift from in-person visits to telehealth. Aetna supported providers during this transition by offering education on the new billing codes and procedures for telephonic and video conferencing visits. We also provided ongoing support to troubleshoot any issues.

## Managing care for children with serious emotional disorder [BA39]

Our role in the CSED waiver program administration includes, but is not limited to:

- Execution of provider contracts and ensuring statewide provider capacity
- Case Management, including case management collaboration with the CSED waiver Wraparound Facilitation (WF) and the Child and Family Team (CFT).
- Prior authorization and utilization management of CSED waiver services
- Development and execution of the Plan of Care (POC); validating the POC includes a crisis plan and a back-up crisis plan; and review of the POC prior to service authorization.
- CFT assistance and securing services
- Claims processing and reporting
- Quality assurance and quality improvement activities
- Grievances and appeals
- Hospitalization and death data reviews
- Incident management process and oversight

Cory is a 14-year-old on the CSED waiver who was taken into state custody at the age of two. After experiencing multiple placement changes, including several residential facilities due to threats of self-harm, Cory moved in with his grandmother. Cory and his grandmother met with their CSED wrap facilitator once a week to ensure services were in place and to coordinate with the Aetna Better Health Care Manager.

Things were going smoothly until the family lost their home to a fire. Thankfully no one was hurt, but they were left with nothing except the clothes they were wearing. While the wrap facilitator stayed with the family to provide support, the Aetna Better Health care manager found clothing, household items and personal hygiene items for the family, and connected them to HUD resources. Cory and his grandmother were very grateful for our support in getting through such a traumatic event. The Aetna Better Health Care Manager involved won the 2022 iCare Award for her work with the family.

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**As of September 2022, Aetna has served 1,061 members receiving CSED waiver-type services.** The Aetna care managers involvement provides an extra layer of support. They can give more attention to the medical and behavioral health needs of the child or youth as well as provide advocacy and find resources. This is vital to families finding success, as navigating multiple systems can be overwhelming and challenging.

## Specialized programs, policies and procedures for CSED waiver

To meet the unique needs of children receiving CSED waiver services, we implemented innovations such as the inclusion of embedded staff at key providers/facilities and BSS offices, and the expansion of our CSED waiver team to include 17 behavioral health (behavioral health) care managers, 6 RN care managers, and 2 managers. We are also reviewing our staff modeling to possibly include a blended caseload methodology to allow for 1:17 ratios for members receiving CSED waiver services who benefit from a wraparound facilitator. All care coordinators who serve these members will be trained in wraparound-informed strategies.

The table below outlines the number of authorizations per service for children participating in the CSED waiver program since the program's inception through September 30, 2022. The top three services requested through the CSED waiver program are wraparound facilitation, in-home family support, and family therapy.

| Description | Count | Description | Count |
|---|---|---|---|
| Wraparound Facilitation | 878 | Peer Parent Support | 99 |
| In-Home Support | 643 | Assistive Equipment | 85 |
| Family Therapy | 590 | Independent Living Skill Building | 64 |
| Respite Care: Out of Home | 238 | Specialized Therapy | 16 |
| Mobile Response | 202 | Job Development | 14 |
| Respite Care: In Home | 166 | Community Transition | 4 |
| Non-medical Transportation | 126 | Supported Employment, Individual | 2 |

**From March 2020 through September 2022, Aetna has paid 21,342 claims for CSED waiver services.**

**Safe at home.** We support the use of trauma-informed wraparound services, such as the current Safe at Home approach for children and youth in West Virginia, especially children enrolled in the CSED waiver. Safe at Home places importance on community recognition of the impact of trauma and on family engagement in service planning. Care planning is conducted with the goal of keeping children and youth in their homes and communities when it is safe to do so.




The wraparound approach is critical to reduce foster care and congregate care and to prevent re-entries. Additional goals include the reduction of the placement of children in out-of-state services and increase in the step-down of youth from placements and/or reunification with family. These goals are achieved via trauma-informed assessments and delivering trauma-informed care.

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## EPSDT

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| BA05 | The Vendor should establish medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for populations eligible for medical services.<br>The Vendor should demonstrate its understanding of medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, according to the Vendor's experience and the policies, procedures, and requirements outlined in Appendix 3: Service Provider Agreement (SPA). |
| BA06 | The Vendor should establish processes specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in all geographic areas, for populations eligible for medical services.<br>1) The Vendor should specify activities that will be performed for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and responsible staff/departments.<br>2) The Vendor should demonstrate its understanding of American Academy of Pediatrics (AAP) EPSDT standards, including, but not limited to, time frames for a child placed within foster care to receive the initial health assessment and comprehensive EPSDT exam. AAP EPSDT standards can be found in the periodicity screening schedule at the following link: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf<br>3) The Vendor should demonstrate its understanding of the Agency's Foster Care Child Welfare Policy and the HealthCheck (EPSDT) program, including, but not limited to, evaluation time frames and periodicity schedules. The Foster Care Child Welfare Policy can be found at the following link: https://dhhr.wv.gov/bcf/policy/Documents/Foster%20Care%20Policy%20December%202021.pdf Information on the HealthCheck program can be found at the following link: https://dhhr.wv.gov/healthcheck<br>4) The Vendor should detail how its plan will be accomplished in all geographic areas. |
| BA07 | The Vendor should develop and distribute materials to inform members, caregivers, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, for populations eligible for medical services.<br>1) The Vendor should explain what materials it will develop to inform members, caregivers, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.<br>2) The Vendor should explain how it will emphasize EPSDT services to children receiving primary care from a specialist. |
| BA08 | The Vendor should use reports and other tools to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.<br>The Vendor should describe reports, and other tools if applicable, that will be used to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Vendor should provide sample reports, dashboards, and/or other outputs to demonstrate EPSDT monitoring capabilities. |

**Aetna has over 26 years of experience in West Virginia implementing the EPSDT programs, including for children in foster, adoptions, post-adoptions and other complex cases.** Our network provides accessible comprehensive and preventive health care services to all eligible members. These services, which do not require prior authorization (PA), include EPSDT requirements of routine screenings, developmental screenings, and social/mental/physical health screenings as listed in Section 1950(a) of the Social Security Act as mandated by the Omnibus Budget Reconciliation Act of 1989. The table below provides Aetna's performance for some key HEDIS ® in comparison the national average.

| HEDIS Measure | Aetna HEDIS MY2021 Rates |
|---|---|
| Well-care visits in first 30 months of life (15 – 30 months) | **14.97%** higher than national average |
| Annual Dental Visit—Total | **15.31%** higher than national average |
| Immunizations for Adolescents—Combo 1 | **2.81%** higher than national average |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total | **34.78%** higher than national average |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI% Total | **6.34%** higher than national average |

To increase utilization of EPSDT services and screenings, Aetna:

- Provides notification of screening due dates

- Educates members, caregivers, and providers about the EPSDT program
- Complies with the State-determined periodicity schedule, American Academy of Pediatrics' (AAP) periodicity schedule, and standards of care for children in foster care
- Makes and tracks referrals and treatments
- Reports results in our encounter reporting and as necessary to meet federal requirements

We also regularly review key data by demographics to monitor for potential disparate care. If identified, we take immediate and appropriate action to reduce the disparities; improve care for the identified population; and mitigate any barriers that might prevent members from having their health care needs addressed.

We recognize annual in-person ESPDT visits decreased due to COVID-19 as members were unable to complete in-person visits. However, we are taking active measures, as outlined below, to ensure 100% of members complete their EPSDT screenings and services moving forward. For example, we are collaborating with the Office of Maternal Child and Family Health to enter EPSDT appointments into FamilyConnect, which triggers a notification to our care coordinators for member follow-up to ensure members plan to attend the EPSDT visit and to address any barriers to care, including transportation. Care coordinators can assist members with rescheduling appointments and securing NEMT to and from the appointment.

FamilyConnect also includes the member notification letter informing members about EPSDT services, a well-check schedule, and the periodicity schedule distributed to members. BSS caseworkers can also access this information and redistribute it to the member as needed.

Aetna has written policies and procedures for providing the full range of EPSDT services to all eligible enrollees up to age 21, in compliance to provisions in the Model Purchase of SPA for Fiscal Year 2022, Section 2.2.3 EPDST. Our care coordinators begin outreach to new members immediately to help members schedule EPSDT services and assist with referrals as outlined in the Model Purchase of SPA 2.2.3.4

## Determining medical necessity for EPSDT services [BA05]

Aetna determines medical necessity for EPSDT services for our members on a case-by-case basis, taking the needs of each child into consideration. EPSDT services, offered via the HealthCheck program in West Virginia, are fully covered and are key to making sure children and adolescents receive appropriate preventive, dental, vision, behavioral health, developmental, and specialty services. Members are entitled to as many doctor visits, hours, and amount of any services as medically necessary for their individual conditions if authorized under EPSDT. Some EPSDT services require PA, and the HealthCheck program consistently reviews evidence-based guidelines to determine medical necessity. Aetna's guidelines cover the entire continuum of care and include specific considerations for children and adolescents.

Aetna also maintains a process for review of program exception requests. For example, during the provision of EPSDT services for a member, a PCP requests a service that is not an Aetna-covered benefit. The process for reviewing a PA request for a program exception (a requested service that is not a covered benefit) includes the following:

- The provider requests coverage for items or services noted to be for a program exception or the request outlines benefits not covered

- The nurse collects all necessary information and provides it to the medical director, who uses the EPSDT federal criteria in accordance with the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50- 62. These criteria are taken into consideration in the course of each service authorization. We use the following guidelines when reviewing the request:
  - Payment or the procedure is not allowable according to the fee schedule, is a type of service covered by the program, and is generally accepted by the medical community (e.g., enclosed safety beds, lead abatement, adaptive car seats, adaptive strollers, or an air conditioning unit for a child with significant asthma)
  - The procedure is not experimental
  - There is medical necessity for the item or service
- We fax or mail the determination to the requesting member and provider and document activity in our electronic claims management system

## Processes specific to EPSDT [BA06]

Aetna is committed to working with providers to make sure all members under the age of 21 receive EPSDT services through the HealthCheck program, according to the **Department's Foster Care Child Welfare Policy,** and their parents, caregivers, and providers use resources effectively. Staff from our UM, care management, quality management, provider relations, and member services departments are all instrumental in the implementation of our EPSDT policy to meet West Virginia's requirements for making EPSDT services available and accessible to our members. Aetna leverages our extensive experience implementing and maintaining EPSDT programs in West Virginia and other states to ensure children and adolescents receive comprehensive preventive, dental, behavioral health, and developmental and specialty services.

### Compliance with EPSDT standards and timeframe requirements

Aetna follows the **Bright Futures/American Academy of Pediatrics (AAP)** and the **AAP's Fostering Health: Standards of Care for Children in Foster Care** recommendations and timeframe requirements for Preventive Pediatric Health Care as the guide for EPSDT services as demonstrated in below.

| Age | HealthCheck Timeframe Requirements |
|---|---|
| Infants from birth to age one month | Every two weeks |
| Infants from age one month to six months old | Every two months |
| Children from six months old to 18 months old | Every three months |
| Children aged eighteen (18) months old to 36 months old | Every six months |
| Children ages 36 months through age 20 | Annually |

Care coordinators ensure members complete a comprehensive HealthCheck exam within 30 days of enrollment or within 30 days of placement in foster care and a follow-up visit within 90 days of enrollment. **Our goal is to complete EPSDT services within 72 hours for children in an emergency or crisis situation.** We collaborate with caregivers to confirm the child has not yet received EPSDT services to avoid duplication. Through our **First in Care program,** care coordinators work with DHHR and the caregivers of members entering or re-entering foster care to obtain members' medical records, identify medical homes for the members, and schedule HealthCheck appointments within required timeframes. Members in a relative/kinship placement are scheduled for a HealthCheck screening within

five days of placement. We recognize some members are not automatically enrolled within five days of placement, and we are committed to working with DHHR to augment this process so we can engage members as quickly as possible after a placement. Our care coordinators also monitor gaps-in-care reports and review gaps in screenings and services with members and their caregivers as part of their regularly scheduled contacts.

The initial and comprehensive EPSDT screenings include, but are not limited to, the following:

- Comprehensive behavioral health and physical health (PH) health and developmental history
- Unclothed physical exam
- Laboratory tests (including blood lead screening appropriate for age and risk factors)
- Vision testing
- Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
- Hearing testing
- Dental services (furnished by direct referral to a dentist for children beginning 6 months after the first tooth erupts or by 12 months of age)
- Health education (including anticipatory guidance)
- Inter-periodic screenings to determine the existence of a suspected illness or condition, or a change or complication to a pre-existing condition

In addition to the preventive services covered under EPSDT, our care coordinators collaborate with our UM team to make sure medically necessary **EPSDT special services** are covered for members, as needed (e.g., formula for premature newborns or infants that are failing to thrive; that are not thriving; orthodontics; listening devices)

### Addressing barriers to EPSDT services

Our network includes every school-based clinic, FQHC, RHC's, group home, and CSED waiver provider in the state. However, we understand the challenges in meeting all the health care needs of our members. To increase access to care and utilization of EPSDT, members can utilize local pharmacies for EPSDT-covered benefits including immunizations, urgent care visits, follow-up urgent care visits, and assistance with transportation and scheduling.

### Managing EPSDT across all geographic areas

To manage EPSDT across all geographic areas, we have care coordinators strategically located throughout the state of West Virginia. Our care coordinators live where our members live, in both urban and rural parts of the state, allowing them to coordinate members' care effectively and efficiently. They work with caregivers to locate an appropriate provider and make sure members complete their necessary EPSDT screenings and services.

We utilize our provider partnerships with FQHCs and RHCs to increase access to EPSDT services in rural areas, such as the eastern mountains.

**Our comprehensive PCP model.** Our analysis of provider satisfaction survey results and ongoing conversations with providers indicated Aetna PCPs would benefit from additional support to drive clinical outcomes and enhance PCPs' engagement in value-based care.

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Aetna's Comprehensive PCP Model places PCPs at the forefront of managing members' care. To allow our providers to focus on their patients, we offer dedicated support to resolve the administrative burdens that come with managing a provider practice. Our model will allow dedicated Aetna staff to be aligned within a Provider Optimization Delivery (POD) structure to meet a provider's needs. For example, our POD surrounds the provider with experts in operations, member engagement, value-based care, and population health. Each POD consists of a Provider Support Representative, a Provider Operations Coordinator, and a Quality Practice Advisor. Our model will work directly with our PCP provider groups to track, monitor, and analyze utilization data and trends. We will leverage utilization and quality data to support interventions and offer value-based provider incentives around HEDIS to measure performance and reduction in ER utilization.

- AG is a 6-year-old boy diagnosed with generalized anxiety disorder, among other conditions. He was referred to intensive care management because he could not complete routine exams without being sedated. Working with AG's mother to assist in meeting his needs, the CM obtained a telehealth evaluation with a child psychologist at WVU, who recommended anxiety medication for AG but could not prescribe it themselves. AG's mother was able to get a prescription after the CM advised her to check with AG's PCP. After AG experienced side effects from his first medication, the CM worked with his mother to reschedule his follow-up appointment so that he could start a new medication before his cognitive evaluation, which AG successfully completed. He was diagnosed again with generalized anxiety disorder and advised to attend behavioral therapy as well as continue his medication.
- AG's behavior improved drastically while on medication, and he began performing better in school and at home. Prior to his dental exam, AG took a COVID test, which he was able to tolerate because of his medication. During AG's dental exam, which was completed without issue, the CM worked with providers and coordinated care for AG to receive his needed vaccines while under sedation, eliminating the need for an extra appointment. Warned by AG's mother that he would likely neither speak to nor acknowledge them, the CM conducted an in-person visit with AG, during which AG brought out and talked to CM about his toys and hamster his mother could not believe it. She has scheduled AG for behavioral therapy with the same therapist who did play therapy with him in the past. AG's mother is very thankful for the assistance received through care management and that her son is now able to better function with his anxiety.

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**EPSDT Profiles.** We use gap in care reports available in Availity, quarterly measures, and incentive programs. We share pediatric measures with network providers quarterly for quality improvement purposes. We generate these EPSDT Profiles for each provider or practice and include items such as well-visit rates and well-visit components.

**Member and provider incentives.** We use value-based purchasing and incentives to encourage statewide compliance with EPSDT, including high-volume providers such as Charleston Area Medical Center, West Virginia University, and Marshall Health. Our value-based agreement with Marshall Health includes quality measures for well-child visits (three to six years), adolescent well care, and childhood immunizations; and our value-based agreement with Charleston Area Medical Center includes quality measures for annual dental visits (children two to three years) and childhood immunizations.

In addition, Aetna aligns its member and provider incentives to drive healthy behaviors and improve outcomes for members. For example, our incentives for EPSDT services include:

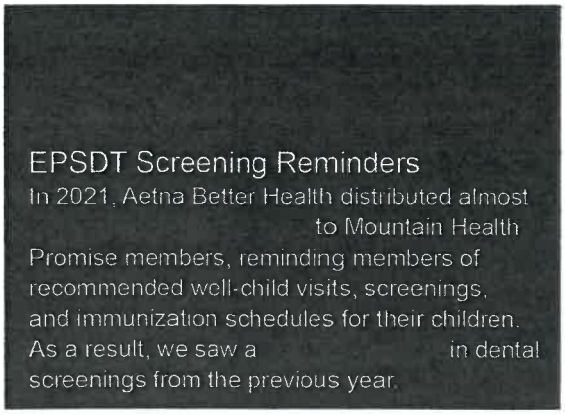
- Members: $25 incentive for members ages 3 to 21 years who complete their annual well-child visit
- Providers: $25 incentive per eligible claim for providers who complete a timely well-child visit for members

**We are actively contracting with tertiary pediatric care facilities in Washington D.C. and Pittsburgh to increase access to EPSDT services and to address patterns of care in the panhandle regions of the state.** In addition, we collaborate with the State to support the completion of well-child exams and other key screenings and services. For example, the Deputy Commission

requested Aetna's assistance in Berkeley County, where the county was experiencing major staffing shortages and needed support to address members' needs. In addition to the extensive support, we provided to Berkeley County (as described in BA03), our care coordinator who, in turn, assisted members with completing needed EPSDT screenings and services.

## EPSDT education and outreach [BA07]

Aetna recognizes the importance of EPSDT education and outreach that occurs early and often for members, caregivers, and providers. We utilize a multimodal communication approach to EPSDT education and outreach. Care coordinators outreach new members to assist with scheduling an EPSDT appointment within 72 hours of identification on the enrollment file. We also send members a welcome packet with information on the availability and benefits of timely EPSDT services, including information on:




- Preventive health care
- Services available under the EPSDT program and where and how to obtain those services
- Timeframe and frequency requirements for regular EPSDT screenings based on the member's age, as indicated by the West Virginia Periodicity Schedule and in alignment with Bright Futures/American Academy of Pediatrics and AAP's Fostering Health: Standards of Care for Children in Foster Care
- Availability of the EPSDT program and services at no cost to members under the age of 21
- Availability of transportation and appointment scheduling assistance through our care management and member services departments

Our CHWs educate members in their communities, working with school nurses, school health advisory committees, and parent-teacher associations to provide information for families (including kinship care, foster, and adoptive families) and Agency caseworkers regarding EPSDT services for children and youth. The CHWs explain these benefits using plain language, paying particular attention to the guidelines that are immediately applicable to caregivers' children. Some CHWs are embedded part-time in primary care practices to provide supports, including but not limited to providing member lists, assisting with calling, and scheduling appointments.

We also issue regular preventive screening reminders and additional EPSDT education and training throughout the year to help members, parents, and caregivers understand the importance and potential health impacts of timely and complete screenings. We have interpreter services and EPSDT information available in other formats, such as large font, braille, and other media for members with vision and hearing impairments. We also offer free translation and interpreter services for members with a primary language other than English.

Our EPSDT education and outreach efforts include IVR (interactive voice response) calls, mailings, member services, website information, and live events

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| Tailored Telephonic Reminders | • Based on age and periodicity schedule to members under the age of 21 and their caregivers. |
| Print Media and Mailings | • Print media is carefully created to be concise and easily understood.<br>• Mailed letters educating members about available EPSDT services with the periodicity schedule<br>• Postcard appointment reminders, and newsletters with age-appropriate recommendations as well as growth charts printed with the well-child visit schedule |

**Provider education and outreach.** Aetna provides specific training to PCPs regarding the importance of EPSDT screenings and appropriate referral process. Our training educates providers on the American Academy of Pediatrics standards of care and reviews the process for referring members to specialists, including behavioral health providers. Training specifically addresses the West Virginia EPSDT periodicity schedule and requirements that PCPs must perform oral health assessments, evaluations, prophylaxis, and oral hygiene counseling. We also educate providers about the AAP's Fostering Health: Standards of Care for Children in Foster Care.

We educate providers on adopting a trauma-informed approach while performing all EPSDT services, including conducting routine physical examinations; screening for developmental delay through the fifth year; screening for autism spectrum disorder; conducting a comprehensive unclothed physical examination; administering all appropriate immunizations, laboratory testing, and health education during each medical screening. Education activities emphasize the importance of using validated developmental screening tools, with the expectation that providers will assist families with scheduling appointments for timely, early periodic screening visits along with any additional assessments, referrals, and follow-up, as well as follow up with families whose children miss their screening visits.

Through our collaborative efforts and education activities with PCPs, parents, caregivers, and others, we promote timely completion of EPSDT services.

### EPSDT services for children receiving primary care from a specialist

In the event a member elects to have a specialist serve as his or her PCP, Aetna care managers reach out to the specialist to participate in care planning. If the specialist is new to performing the functions of a PCP, we educate them on the requirements of being a PCP and monitor them through gaps-in-care reports for relevant HEDIS measures and member feedback on appointment access or practitioner behavior. We provide ongoing support and use the same interventions as we would use for non-specialist PCPs.

For providers (both PCPs and specialists who function as PCPs) who show low compliance rates, the QM team reviews a sample of records for additional investigation. This assessment of outcomes becomes a part of the quality plan, and both the UM and QM teams review outcomes with the providers and CM team. We also encourage providers to perform well visits in tandem with acute visits to record preventive services through coding and emphasize that providers can either address EPSDT requirements while the member is in the office or schedule additional follow-up for an EPSDT visit.

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In 2021, the Clarksburg community was exposed to potentially high levels of lead in the drinking water. While State and local authorities provided residents with filtration systems and bottled water,

ABHWV distributed flyers to members living in the area and outreached all 145 members in the Clarksburg community. Of the members contacted, only 1 had a significant lead level that required intervention. Our care management team contacted a Clarksburg foster family who had recently fostered three siblings enrolled in Mountain Health Promise. Unaware of the current situation, we informed the family about the potential lead exposure and encouraged the foster parents to bring the members to the pediatrician immediately. Although the members had recently been moved to a foster home outside of the area, the foster parents stated they would bring the siblings to the pediatrician immediately. Care management provided information about a free lead testing location in the area and the direct callback number for the family to use if they had additional needs. The family expressed sincere gratitude for the outreach, education, and follow-up information provided.

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## Reports monitoring EPSDT compliance [BA08]

Aetna has implemented various strategies to monitor compliance in West Virginia and in 12 other states in which we serve children and youth that have proven highly effective in improving engagement in screenings and preventive services.

Regular monitoring helps us to identify strategies that are working well and provides insights into areas where we can overcome our members' barriers to care. We analyze EPSDT screening and well-visit rates monthly and quarterly using our HEDIS dashboard. Figure E.1-3 shows the measurements in more detail including: members' well-child exams, dental visits, lead screenings, and more. This data is supplemented by the EPSDT reports showing EPSDT outreach services, and rates of screening and referrals, well-care child visit, dental visits, and immunization. EPSDT reports are submitted to DHHR within 45 calendar days after the end of each quarter.

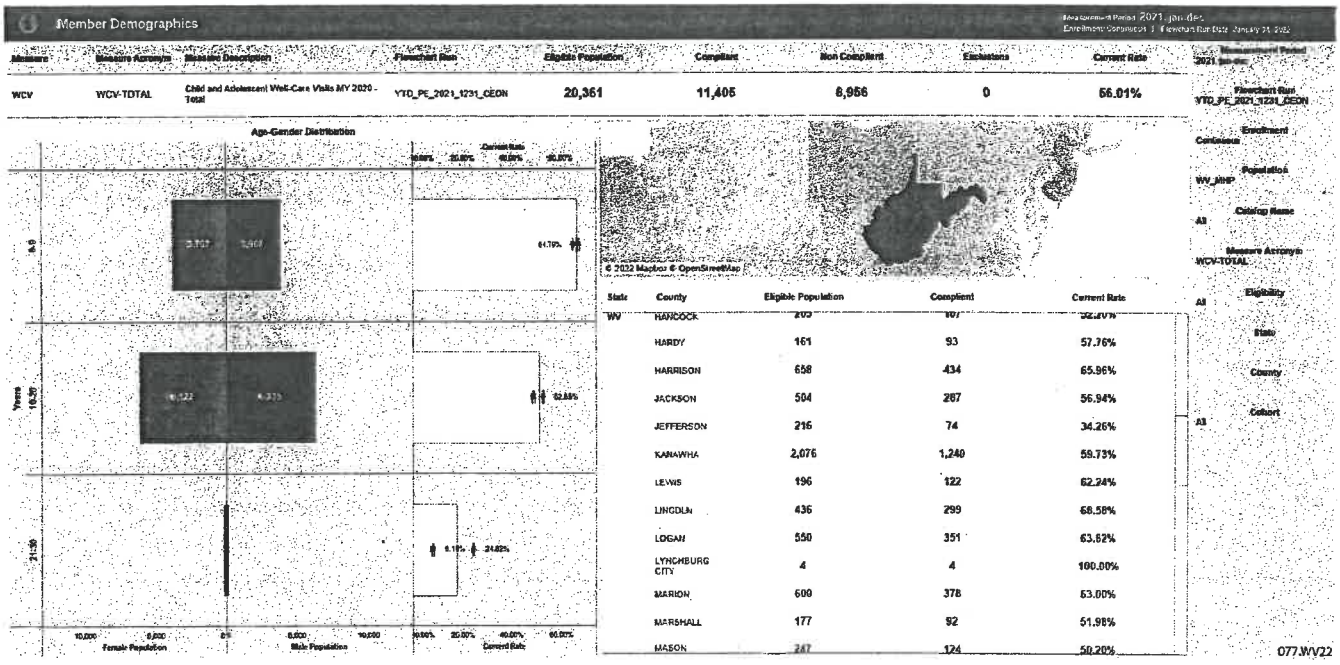


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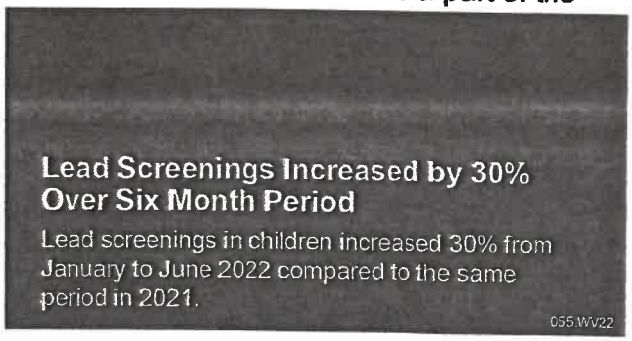
***Figure E.1-3:*** *Aetna HEDIS dashboard*

Our care management platform uses the data from these reports and dashboards to help care coordinators identify and close gaps in care. Aetna's regionalized local CCTs set task reminders for follow-up visits for children ages 5 and under with no screening, targeting children and youth with special health care needs who are behind on their screenings and conducting outreach to parents/caregivers of members ages 0-20 who are behind in their well-visit screenings. We use care alerts (which identify high- and medium-risk members who are behind in their care), priority lists, quarterly measures, provider profiles, tracking phone calls (automated and direct), and face-to-face contacts. Pediatric measures are shared with the network and practices quarterly for quality improvement purposes. We will generate an EPSDT profile for each provider or practice, which will include scorecards on items such as well-visit rates.

Aetna utilizes data and reporting to identify areas for continuous quality improvement. We examine the data collected to look for gaps in performance as well as measures with positive outcomes. We look for member, provider, and geographic differences, and search for any data issues that are affecting performance. EPSDT oversight and compliance reviews include the following:

- Timely EPSDT screenings completed
- Timely completion of services members are referred to as part of EPSDT
- Authorizations for EPSDT services in utilization management
- Turnaround time reporting for key services related to EPSDT exams
- Claims audits to test claim edits and rules
- Identification of members who need EPSDT screening or who have no record of completed services

For providers who show a low compliance rate, the quality management team will obtain and review a sample of records for additional investigation. This assessment of outcomes becomes a part of the quality plan, and both the UM and QM Teams review outcomes with the providers and care management team. We also encourage providers to perform well visits in tandem with acute visits to record preventive services through coding. We emphasize that providers can either address EPSDT requirements while the member is in the office, or schedule additional follow-up for an EPSDT visit.




## Dental

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| BA36 | The Vendor should provide dental services for individuals under 21 years of age as covered services in an amount, duration, and scope to achieve the purpose for which the services are furnished, for populations eligible for medical services.<br>The Vendor should make arrangements with inpatient and outpatient facilities to provide dental services to members with special needs, for populations eligible for medical services.<br>The Vendor should describe how it will meet this specification. |
| BA37 | The Vendor should monitor dental screening utilization on an ongoing basis, for populations eligible for medical services. The Vendor should intervene if a member has not had a dental screening in over one year, for populations eligible for medical services. For foster care members who have not had a dental screening in over one year, the Vendor should escalate the issue to the member's caseworker.<br>The Vendor should describe the process and mechanisms it will use to meet this specification. |

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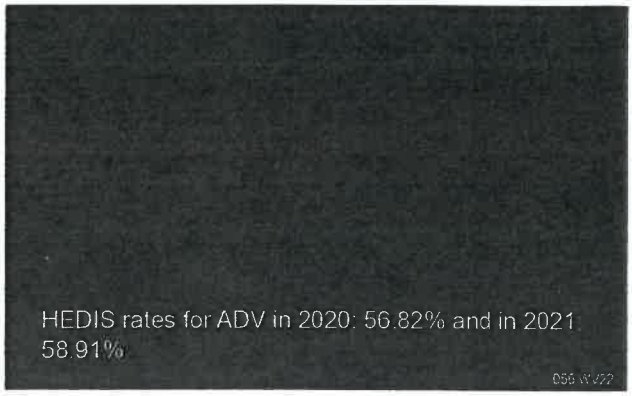
Due to the frequent placement changes and fragmented care many children in foster care experience, new members frequently join our health plan in need of dental services. Through our partnership with SKYGEN USA, our dental benefits administration subcontractor, we can make sure members get the dental care they need in a timely manner. We have been providing Dental Services to West Virginia Mountain Health Promise members since 2020 via SKYGEN USA, which has more than 25 years of experience working with Medicaid populations. Through this partnership, we offer families access to more than 575 pediatric or general dentists, as well as 51 oral surgeons and 37 orthodontists statewide.




Aetna care coordinators will collaborate with representatives from SKYGEN USA to make sure children involved in the child welfare system in West Virginia have access to appropriate and timely dental care.

We are also the only MCO to participate in standalone forums with SKYGEN USA in which their field representative is onsite with Aetna staff and our providers to answer any questions or concerns related to pediatric dental services. All departments within Aetna are represented in the forums, and information is presented to assist with systems, provider incentives, member incentives, claims, issues, and any other topic that the provider requests. **As a result, from 2020 to Q2 2022, our providers have increased dental screenings by 58.6%, with nearly 15,000 children receiving annual dental screenings since 2020.**

Aetna continually monitors data and looks for ways to improve care for the whole person. For instance, we conducted an analysis of Mountain Health Promise members **to better understand the connection between dental care and primary care services and its impact on health outcomes.** The analysis looked at members who completed a primary care, dental, hearing, and/or vision screening from April 2020 through March 2021 and identified their health outcomes for the same period one year later. Key findings include:

- **Depression screenings:** Members who completed a PCP and dental visit had 9.8% higher rate of completed depression screenings (per 1,000 members) than members who only had a PCP visit and 11.7% higher rate than members who had no annual screenings.
- **Antidepressant adherence:** Members who had at least a PCP and dental visit or completed all four screenings/visits during the prior period, had the highest compliance rates for antidepressant adherence in the post period, ranging from 38.5-41% compared to 26.8% compliance for members with no screenings/visits. **West Virginia achieved 4 stars for Adherence to Antidepression Medication the first 6 months.**
- **Mental health outpatient visits:** While members who completed all four screenings/visits had the highest rate of mental health outpatient visits per 1,000 members in the post period at 53.6%, those with at least a PCP and dental visit had the next highest rate at 50.2%. Members with no screenings only had 20.6% per 1,000 members.

## Providing dental services to individuals under 21 [BA36]

SKYGEN USA supports increased utilization of EPSDT dental screening services and necessary diagnostic and treatment services for members under the age of 21 through:

- Furnishing dental services by direct referral to a dentist for children beginning 6 months after the first tooth erupts or by 12 months of age
- Assisting members with finding appropriate in-network dental providers and scheduling appointments
- Assisting members, heads of household, caregivers, and guardians with arranging or scheduling transportation to appointments
- Arranging interpreter services for members with limited English proficiency or members who are hearing impaired, deaf, and/or blind
- Sending out communications to heads of households and PCPs for members who are due or overdue for their EPSDT appointments based upon their birthdates and utilization data
- Collaborating with the dental director and the local or regional Care Connection Team if any medical or other complex needs are identified for our members
- Providing data to our informatics system platform for a single care plan for members
- Conducting dental screenings through our PCPs, who can provide services like sealants and fluoride treatments

**As a result of these efforts, we increased dental screenings by 7.2% in 2021.**

Aetna's regional CCTs provide education and attend community events to enforce the importance of oral health to our members and families in the communities where they live. Dental claims data is fully integrated into our single FamilyConnect record, which is available to Agency caseworkers and all authorized individuals in a member's care team. Our goal is to limit the possible barriers to care and improve regular prevention and early intervention. Aetna also understands the relationship between dental care and SUD and has begun to focus on dental prescribing patterns as well as the oral health of our SUD members. Many individuals with a history of SUD experience opiates for the first time at their dentist's office, and Aetna's campaign works with prescribing doctors to educate on best practices and identify any serious outliers.

As described, Aetna has been collaborating with our dental subcontractor, SKYGEN USA, and the national Aetna Medicaid organization to address the prescribing patterns of our dentists. We have initiated a peer-to-peer notification campaign to identify outlying prescribers and make recommendations based on national prescribing standards. In addition, we offer providers educational opportunities and data to assist in how they address their patients. SKYGEN USA also leverages multimodal communications strategies to notify members of upcoming and periodic dental screenings for applicable populations, including interactive voice response (IVR) outreach campaigns and education materials for members.

When member location changes are noted on the daily eligibility file or through Agency notification, we use geo-access tools to evaluate the member's access to their dental provider within one day of notification. During that same day, we notify the Agency caseworker, caregiver, foster parent, or member if the dental provider no longer meets access standards. After receiving notification, these individuals have two days to choose a dentist. If no dental provider is chosen within three days of identification of the demographic change, Aetna will apply the auto-enrollment process.

### Working with inpatient and outpatient facilities for children with special needs

Our CCTs and SKYGEN USA work with members and their families to ensure care is coordinated between dentists and PCPs and assist members with any issues they experience in accessing dental

care. If the SKYGEN USA call center is contacted to arrange dental services for a children and youth with special needs at an inpatient or outpatient facility, the customer service representative can call the provider's office on behalf of the member to confirm the provider serves children and youth with special needs and treats the member's specific needs. Additionally, the call center will confirm that the provider sees members in the appropriate inpatient or outpatient facility and that the facility can provide dental services under anesthesia or sedation for children who are unable to be served in a general dental office.

SKYGEN USA currently reviews services under sedation or anesthesia for members who require dental services in a hospital or inpatient setting. The customer service representative can also assist with scheduling the follow up appointment, as necessary. SKYGEN USA and Aetna know that members have the best experience when their dental and medical needs are coordinated in an integrated approach to care. This model of care coordination provides a more seamless, cohesive experience for members and their guardians.

When communicating with and planning for members with special health care needs, Aetna's care coordinators encourage the identification and consideration of past trauma (including dental trauma), the member's cultural beliefs, and provider office environment. We emphasize the importance of choosing a dentist experienced in meeting the member's needs and an office that includes the environmental setting most appropriate to meet the individual's specific needs. When appropriate, our care coordinators conduct warm handoffs to SKYGEN USA to obtain further support. These coordination efforts are vital to ensuring the member receives all necessary dental services and all services are provided in a trauma-informed and trauma-sensitive manner.

## Monitoring dental screening utilization [BA37]

Aetna's QM Outreach Team monitors dental gaps in care, including the need for dental examinations, on an ongoing basis through our electronic care management system. When we identify individuals who need dental examinations, a QM outreach coordinator reaches out to the member or caregiver to provide education and assist in scheduling appointments and arranging transportation, if necessary. For members who are not in care management, designated care management associates will monitor and screen for EPSDT standards of dental services, then provide outreach to members as appropriate to ensure compliance.

SKYGEN USA develops specific reports to monitor and analyze dental screening utilization and periodic (monthly/quarterly/annual) analysis of demographics, claims, and encounter data to identify high-risk populations within the membership. Aetna worked closely with SKYGEN USA to define the required data and data integration strategies needed to appropriately monitor dental screening utilization on an ongoing basis. Our member's integrated care record includes their entire oral health history. We meet with out-of-state pediatric residential treatment facilities (PRTF), such as KidLink and Acadia, at least monthly to coordinate and cover other services high-risk members need while residing in a PRTF, including dental and vision screenings, although these services are out of scope for an PRTF and will be delivered by external providers not currently enrolled in West Virginia's Medicaid program.

### Intervention for members who have missed annual dental screenings

Aetna collects information about members' dental screenings and access to dental care during the initial health risk questionnaire, EPSDT screenings, and during member transitions of care. Aetna's local CCT monitors and identifies dental gaps in care and collaborates with the ICT to address them as

part of the care planning process, particularly for new members. We regularly evaluate access data, emergency room data, and claims to better understand the gaps in some of our most remote areas. Our QM Outreach Team conducts data analysis on claims and encounters to determine service areas with the highest volume of care gaps. The QM Outreach Team collaborates with dental wellness providers in these geographic areas to increase access and health literacy for members needing services. Aetna QM outreach coordinators conduct outreach to members and their caregivers with gaps in care residing in these areas to provide education on the need for dental exams. Our care coordinators also continuously monitor for gaps in care and collaborate with the Agency's caseworkers to close the care gap and complete necessary EPSDT screenings. Through this collaboration, we make sure that no member in foster care goes more than one year without a dental screening. In the very rare instance this happens, care coordinators immediately escalate the issue to Agency caseworkers.

To incentivize dental care, **we currently offer a $25 gift card to the guardians of two- to three-year-old members who complete an annual dental visit.** Aetna members earned 198 gift cards in 2021 and 162 gift cards in 2022 by participating in these programs.

## Socially necessary services

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| BA01 | The Vendor should establish a process to implement authorization criteria and a process for providers to request authorizations for socially necessary services (SNS).<br>The Vendor should provide a proposed process to administer authorization criteria for these services in accordance with Appendix 9: SNS Utilization Management Guide. |
| BA02 | The Vendor should develop a process to ensure the most appropriate socially necessary services (SNS) are used to meet the member's and/or their family's needs.<br>The Vendor should describe a detailed process to coordinate the most appropriate socially necessary services (SNS) for the member and/or their family in accordance with Appendix 9: SNS Utilization Management Guide. |
| BA04 | The Vendor should use the family service plan (FSP) and individualized service plan (ISP) information, as applicable from the Agency caseworker, to determine the most appropriate socially necessary services (SNS).<br>The Vendor should describe the procedures and protocols for using the family service plan (FSP) and individualized service plan (ISP) to determine the most appropriate socially necessary services (SNS). |

Aetna understands the importance of provision of socially necessary services (SNS) to support permanency and well-being for children in the child welfare system. SNS facilitates early intervention family services to prevent removal of children from the home and the opportunity to prepare members with independent living skills as they age out of the child welfare system. Kepro, on behalf of Aetna, collaborates and interfaces with the BSS Office of Community Partnerships and all SNS providers to facilitate member access to care and positive social outcomes in a seamless way. **Kepro, on behalf of Aetna, approved 71,323 SNS authorizations in 2021 and 73,465 authorizations for the first eight months of 2022.**

Aetna's model for serving children and youth in the child welfare system includes a social services director and an SNS liaison. Our SNS liaison has nine years of experience as an SNS care coordinator managing SNS utilization management and an extensive background in social and child welfare. The SNS liaison receives all current UM training, with an emphasis on topics such as West Virginia's SNS UM criteria, safety, needs assessments, trauma-informed care, Mental Health First Aid (MHFA), and supplemental training on the needs of foster care children and children receiving adoption assistance.

Aetna conducts at least 6 focus groups each contract year with youth, families, and foster parents that reside in the community and utilize SNS as an opportunity to provide DHHR with feedback on ways to improve the SNS program in terms of access; service delivery; gaps in support systems; engagement with system staff; cultural competency; and member knowledge of services and supports. Key findings and lessons learned in the 20 groups held between March 2020 and June 2022 include:

- Families have expressed frustration related to inadequate communication across the agencies involved in their child welfare cases that causes them to feel uninformed about what expectations must be met for reunification. Due in part to focus group feedback, we identified the need to add a Service Navigator to assist biological families. This approach is being piloted by the Public Defender's Office in Wood County.
- Families reported unprofessional behavior by SNS transportation providers. These reports were echoed in the West Virginia Foster Care Ombudsman's inaugural report. The focus group input, together with this report, led to SNS providers requiring staff to wear identification.

Aetna collaborates with BSS on the questions to be used in the focus groups to ensure the most useful information is being collected. We collect monthly progress reports from SNS providers for each family served by the 10th day of each month.

## Authorization criteria for socially necessary services [BA01]

Aetna has adopted the existing authorization criteria detailed in Appendix 8 SNS utilization management guidelines. We collaborate with Kepro, which has been providing services to DHHR since 2000, to conduct authorization of SNS through the current system of SNS authorization.

Aetna implemented an SNS Oversight Committee through our quality management department to assess under-utilization and over-utilization, unnecessary high costs of care, and confirm members are getting needed services. Aetna uses automated data exchange with Kepro to streamline its authorization review process with support from our SNS liaison, as needed.

### Process for providers to request authorizations for SNS

Kepro processes referrals for SNS submitted by a provider or BSS caseworker through the State's Families and Children Tracking System (FACTS) system within 24 hours. The process begins when the DHHR caseworker enters a SNS in the service plan contained in FACTS, selects a provider, and prints a referral letter. The referral letter is then sent to the identified agency by the Agency caseworker. DHHR provides all the SNS referrals generated that business day in the agreed-upon file layout and transfers it to DHHR's secure site. Kepro retrieves the file, validates the data, loads it into their UM system, and makes certain fields are un-modifiable by providers and UM vendor staff. Service providers log onto the SNS utilization management system to enter remaining data elements and submit their requests.

Kepro utilizes a tiered system for the purpose of authorizing services delivered to BSS members. All data is submitted electronically. Increasing levels of data are required as the complexity of a

During MHP rounds, a CM was reviewing a case where a child, Darrell, was placed out of state and is struggling with responding to treatment and gaining adaptive coping skills. He has only talked to his parents on the phone since his placement in the facility because his parents don't have the financial means to pay to travel to see him. The SNS Liaison recommended that the CM talk to the DHHR worker about referring the parents for SNS Transportation, Meals, and Lodging to pre-pay for trips to see their child in placement. They were given an SNS Transportation referral code that determined whether they drove, rented a car, flew, or took a train. The Aetna CM coordinated the creation of the referral with the BSS worker and Kepro. Kepro helped the parents enroll as an SNS provider, register as a user for the Kepro secure website to obtain authorization for the services, and complete the necessary documentation to be prepaid for their last trip to see Darrell in six months. Now that Darrell's parents have been set up as an SNS provider and can be paid ahead of time for transportation costs, the barrier to in-person time with their son has been removed. Darrell's behavior has improved dramatically and is responding better to treatment. The parents have visited him monthly for the last three months, and he may ready for discharge by the end of next month.

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case increases. Information received is automatically entered into the SNS system, which compares the member data to utilization management criteria. Depending upon the tier, Kepro issues an authorization decision within 5 business days of the authorization request via the secure Kepro website.

Kepro's application process follows CMS security regulations and complies with HIPAA regulations. Aetna has established a fully compliant, secure file exchange and system access capability with Kepro for all two-way data and application access requirements. We utilize industry-standard Secure File Transfer Protocol (SFTP) servers to handle inbound and outbound file exchanges and employ a rigorous combination of automated and manual processes to validate successful exchange of files. Our file monitoring software will alert us automatically in the event of a failure anywhere in the end-to-end process, and if a failure occurs our Production Support team is immediately engaged to research and resolve the issue. We also have a full audit trail for all inbound and outbound files and data processed retained in a separate audit database retrievable for audit and compliance purposes.

## Ensuring the most appropriate SNS are used to meet member needs [BA02]

To support the coordination of person-centered SNS, and ensure each member receives the most appropriate SNS to meet their needs, Aetna has employed specialized CCT staff with expertise serving the population of children and youth involved in the child welfare system and has provided them with additional training related to SNS (e.g., the types of services available and how they support children and youth.) We also train CCT staff in the principles of person-centered planning, TIC, MHFA, LifeCourse tools, and other Aetna trainings available through the Relias Learning Management System, such as training on the West Virginia Child and Adolescent Needs and Strengths (WV-CANS). In collaboration with Kepro, we have provided comprehensive initial and ongoing staff training on SNS.

Our **individualized, person-centered model of support** integrates SNS with physical health and behavioral health services, and other Medicaid (e.g., DME) and non-Medicaid services and supports (e.g., community-based supports to address unmet social resource needs, such as transportation and nutrition) to promote and support health and community tenure for the populations we serve and in accordance with the SNS UM Guidelines. Screenings, such as the Foster Care Health Risk Questionnaire and the Health Care Equity screen are conducted upon enrollment and annually to assess each member's SDoH needs. The tools assist care coordinators to establish goals and interventions that help ensure members' needs are met—including those requiring SNS. **Through our integrated care model, Aetna care coordinators use face-to-face contacts to engage members and their families in SNS outlined in the ISP.**

Care plans, inclusive of SNS, are shared with members and their ICT with appropriate consent. Care coordinators work with members and their ICT regularly and through the reassessment process to monitor SNS delivery, satisfaction with SNS, and address any concerns, gaps in SNS, or other contingencies affecting the delivery of SNS (e.g., creating crisis plans). Care coordinators also address any barriers to accessing and receiving these services—including providing appointment reminders and transportation assistance. In addition, Aetna helps members aging out of the program by coordinating referrals through CBOs.



- **Supporting our members to avoid unnecessary disruption to their SNS, their environments, and their living situations is of paramount importance.** General strategies performed across settings include the following:
- Proactive member outreach through routine ISP meetings, utilization management, member education, and reassessment to identify members at risk of SNS disruptions
- Facilitation of strong SNS provider relationships to support routine communication and integration of up-to-date, external, clinical, and community-based care plans within their Aetna service plan
- Utilization of technology platforms that encourage SNS provider/health plan communication
- Dissemination of user-friendly member and caregiver education tools by the member's assigned care coordinator, member advocates, and the SNS liaison to encourage reporting of gaps in service and how to access a 24-hour health information line and the behavioral health crisis services hotline and available community-based crisis supports to respond to urgent needs
- Follow-up by care coordinators either co-located in a facility or through telephonic contact no less than three days following transition from an inpatient setting back to a community setting to make sure SNS resume timely

## Using a family service plan and individualized service plan [BA04]

Kepro SNS care managers review the family service plan (FSP) and ISP information entered by the SNS provider into the secure Kepro website when authorizing SNS requests. During retrospective reviews, Kepro confirms SNS is included in the FSP and/or ISP. In addition, the members' primary care coordinator reviews the FSP and the ISP with the BSS caseworker and with family and member, as appropriate.

## Behavioral Health Integration

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| BA33 | The Vendor should ensure that primary care providers (PCPs) maintain information shared by behavioral health providers as to the outcome of behavioral health screenings and evaluations, including, but not limited to, in a patient's medical record.<br>The Vendor should describe the process for how it will meet this specification. |
| BA34 | The Vendor should ensure that primary care providers (PCPs) are informed about changes in a member's behavioral health, including, but not limited to:<br>• Hospitalization<br>• Emergency room (ER) usage<br>• Change of medication<br>The Vendor should:<br>1) Describe what method(s) and process(es) it will utilize to meet this specification<br>2) Explain how it proposes to define what constitutes a change in behavioral health status |
| BA35 | The Vendor should assist members in accessing additional services as a result of change in behavioral health status, including, but not limited to, the care coordinator's assistance in making appointments for members. The Vendor should also provide education to members and their caregivers on the availability of such services and the assistance the Vendor can provide to remove barriers to access to care.<br>The Vendor should describe how it will meet this specification. |

Behavioral health integration has been a national movement to provide whole-person care. Integration can look several different ways, including having a behavioral health provider on-site, having one next door, or collaborating closely across town. Data sharing is often done in the same system, with one EHR, but can also be done through interdisciplinary meetings and consistent collaboration.

As an NCQA-accredited MCO, Aetna analyzes collaboration between our PCPs and behavioral health providers annually. Our provider services team provides education about the importance of coordination

of care and encourages sharing of information across the plan to improve care for our members. **When we have the required consent of members**, strong communication links between PCPs and behavioral health providers facilitate two-way exchange of relevant information, such as medical history, current medications, diagnosis, treatment, and changes in behavioral health status. Using our integrated model, Aetna care coordinators monitor signed consent forms for all required parties (including kinship care, foster, and adoptive parents) and outreaches to families to get signed consent when forms have not been completed. We protect all Protected Health Information per federal regulations. Aetna acts, as necessary, to improve continuity and coordination of care across the health care network based on routine assessments.

## Ensuring PCPs maintain information from behavioral health providers [BA33]

Aetna offers initial and ongoing provider trainings, including our new provider orientation and ongoing provider workshops, that support a holistic and collaborative approach to members' care. Our provider manual educates providers about their contractual requirement to maintain information shared by behavioral health providers as to the outcome of behavioral health screenings and evaluations in a patient's medical record.

Similarly, our provider manual requires behavioral health providers to communicate behavioral health assessment information and ISPs to members' PCP. To further support early identification of members' behavioral health needs, we provide training and education to PCPs on how to identify members with behavioral health needs and make appropriate referrals for behavioral health services. We also distribute member materials, including a behavioral health brochure and the member handbook, that encourage members to communicate behavioral health information to their PCPs.

Aetna acts, as necessary, to improve continuity and coordination of care across the health care network based on routine assessments.

Continuity and coordination of care activities between medical and behavioral health care include the following:

- Monitoring data trends for opportunities to improve the exchange of information
- Assessment of the appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care
- Assessment of the appropriate uses of psychopharmacological medications
- Assessment of the management of treatment access and follow-up for members with coexisting medical and behavioral health disorders
- Implementation of primary or secondary preventive behavioral health programs
- Assessment of needs of members with severe and persistent mental illness

## Keeping PCPs informed on changes in member's behavioral health [BA34]

Integrated care is an organizational priority at Aetna. We purposely did not create a separate business unit for behavioral health services; rather, our business model incorporates our integrated care model so that our care coordination team understand and address all physical, behavioral, and social aspects of health care. Aetna partners with states to make physical and behavioral health integration a priority.

Aetna assesses all members for new PH and enrollment and conducts reassessment annually or more often as indicated by a change in condition. We run our predictive risk stratification analysis on all members monthly, which will also alert us to changes in behavioral health. We review the member's

care plan and develop a specific follow up schedule based on risk level. All initial and subsequent care planning activities are tracked in the written care plan and in Aetna's care management business application system.

Aetna has designed FamilyConnect for the purpose of integrating all components of the delivery of care to our members. The system has the capability to securely store and transmit information and interfaces with subcontractors and other relevant systems, including the West Virginia Health Information Network, DHHR's MMIS, and report data in a format specified by DHHR. Aetna has years of experience with HL7 transaction format, and we are Fast Healthcare Interoperability Resources-compliant as directed by CMS. The data systems are integrated so that the member's data can be compiled in one central source. The information is housed within our integrated informatics system.

**Hospitalizations, ER usage, and changes in medications.** Our care coordinators conduct daily monitoring of hospitalizations and frequent ER usage through CMT. We conduct outreach to members with frequent hospitalizations or ER usage to enroll the member in case management or to conduct a reassessment of the member's needs to initiate or update the member's care plan. Care plans facilitate communication between the member's PCP and specialty care providers, including behavioral health and medications reconciliation.

### Defining a change in behavioral health status

A change in behavioral health status is defined as when a member's behavioral health needs can no longer be safely met in an outpatient setting and a higher level of care is indicated. This includes admissions to inpatient behavioral health, crisis stabilization units, RMHTF, any of the American Society of Addiction Medicine (ASAM) residential levels of care, the use of crisis response teams, and referrals for Wrap Around / CSED waiver services. A change in behavioral health status would also include change in medication, and a member's readiness to discharge to a lower level of care, including outpatient services.

## Assisting members to access services due to change in behavioral health status [BA35]

Aetna uses the CAFAS to inform members' level of care, the type of treatment needed, and to detect a change in behavioral health status. If the CAFAS indicates a member is currently in the wrong level of care, the member's MDT convenes to review the member's needs and identify next steps. Care coordinators monitor members' CAFAS monthly to begin discharge planning with providers whose members are ready to receive behavioral health care in the community.

We provide person-centered, culturally competent support to help members access additional services to address a change in behavioral health status. For example, when members are admitted to behavioral health inpatient, PRTF, and residential settings (including both in- and out-of-state placements), care coordinators follow the member through their residential stay. We also participate in members' facility care planning meetings and ensure ongoing member communications. Care plans will be updated if there is a change in the member's physical or behavioral health conditions, the need for SNS, or a significant change in SDoH. We coordinate the discharge follow-up appointments and ensure that medications are available at time of discharge. **If a member is being transferred to a new facility, our care management staff connects the facility's prescribing physician to the pharmacy to make sure prescriptions are transferred and authorized.**

We evaluate a member's progress toward their goals and determine if the current care plan is meeting the member's current needs through regularly scheduled contact, recurring reassessments, and use of

assessments following events which have altered a member's health status. The care coordinator identifies appropriate providers for the services identified in the care plan based on the re-assessment due to the change in condition and helps schedule appointments as needed. Providers are selected by the member and family based upon their preferences and cultural considerations.

Care coordinators outreach members to assist with appointment scheduling and transportation to the visit, if needed. We educate members and caregivers about the availability of these services through our member handbook, website, and care management brochures. Care coordinators also inform members about these services during the care planning process.

## Collaborating with out of network providers

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| BA24 | The Vendor should develop and implement guidelines under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the Vendor's network) if it is considered to be in the best medical interest of the member, as determined by the member's primary care provider (PCP) and/or the medical director.<br>The Vendor should:<br>1) Describe the circumstances and process under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the managed care organization's [MCO's] network) if it is considered to be in the best medical interest of the member<br>2) Specify how long it will allow members to see out-of-network providers that refuse to contract with the health plan for ongoing courses of treatment past the first 90 days |
| BA22 | The Vendor should ensure that information from non-network providers is shared with the member's primary care provider (PCP).<br>The Vendor should explain the procedures for ensuring that information from non-network providers is shared with the member's primary care provider (PCP). |
| BA27 | The Vendor should transition the member from an out-of-network provider to an appropriate in-network provider if the member is currently seeing a provider that does not participate in the network.<br>The Vendor should assist in transferring necessary clinical information to the foster care member's new in-network physical health or behavioral health provider.<br>The Vendor should:<br>1) Describe the process by which the Vendor will work to meet these specifications<br>2) Explain how the Vendor would propose to define an "appropriate" in-network provider |
| BA29 | The Vendor should facilitate timely payment for services for in-network and out-of-network providers, for populations eligible for medical services.<br>The Vendor should describe how it will meet this specification. |

Aetna's comprehensive provider network includes PCPs, medical specialists, behavioral health specialists, and all FQHCs, and RHCs across West Virginia. We extend members' access to care through our partnerships with virtual physical and behavioral health care services such as Groups Recover, PursueCare, and Bright Heart Health. We are also working to collaborate with Flourish Health to address serious mental health issues for the adolescent population. In cases where a member's current provider is not contracted or when a provider type does not exist in the area, we will authorize services to provide continuity of care for our members. When necessary to meet a member's unique, whole-person needs, Aetna allows out-of-network services for both non-emergency and emergency situations. Prior authorization is never required for in- or out-of-network emergency services. Out-of-network providers are invited to join the network, and single-case agreements are initiated when necessary. **Aetna contracted with 14 new providers as a result of single-case agreements from October 2021 to September 2022.**

## Continuing existing relationships with out-of-network providers [BA24]

If a member has an established relationship with an out-of-network provider or a member is seeing a provider that leaves our network, Aetna will allow continued medically appropriate services for 90 days

or longer until an alternative in-network provider can be found or until the provider enrolls in the network. Aetna establishes single case agreements to facilitate continued access to out-of-network providers, as appropriate.

When the member's PCP or our medical director determine it is in the member's best medical interest to continue seeing an out-of-network provider, Aetna will grant an extension to complete the course of therapy to avoid a disruption in care, depending on the type of service and the member's place in the timeline of treatments. Concurrently, we work with members and providers to find appropriate providers within our network to provide the service. Aetna welcomes out-of-network providers to join our network and establishes single-case agreements with out-of-network specialists in West Virginia or outside the state when medically necessary and the specialty care is not available within our network.

In some instances, a member needs to see an out-of-state provider for medically necessary specialty care that is not available within our network. Our provider services representatives work with the out-of-state provider to establish a single-case agreement and help them enroll in West Virginia Medicaid, allowing them to serve the member and receive timely payments for the care provided.

Our pilot program with KidLink Treatment Services aims to reduce provider payment issues with out-of-network providers. Through KidLink, we can cover medical, dental, and vision services offered by providers who are not enrolled in West Virginia Medicaid. We are also exploring innovative payment methods to incentivize these out-of-state providers to join our network.

### Ongoing courses of treatment past 90 days

Requests for continuation of out-of-network services beyond the first 90 days of enrollment are reviewed individually by our CMO. Approval or denial of these requests are dependent on the availability of services in-network, within reasonable travel distances, and the condition that resulted in the request. Aetna will offer extensions in special circumstances. Urgent requests for extensions are reviewed within 48 hours and nonurgent requests within 7 calendar days.

## Sharing information from out-of-network providers with PCPs [BA22]

Sharing information across multiple system agencies, placements, and providers is of prime importance to provide care for children and youth involved in the child welfare system. Aetna's regional CCTs facilitate information sharing through the strong relationships they have developed with providers of all types across West Virginia. Care coordinators share information regarding non-network provider claims and services with the member's PCP. Our network PCPs are also invited to use our electronic population health management platform, which collects and displays data on their utilization, including with non-network providers.

To further support seamless continuity of care and reduce fragmentation, Aetna contractually requires out-of-network behavioral health providers to share information with the member's PCP, and other providers as appropriate, through its single-case agreements. Aetna actively reviews claims data to identify when members see out-of-network providers. Once identified, we notify the member's PCPs and remind them of their contractual obligation to request the member's records from the out-of-network provider, which must be provided within 14 days. Our staff follow up with PCPs to ensure they request member records when needed. When a member chooses a new provider within Aetna's network, we assist them with requesting the transfer of their records to the new provider.

We encourage all providers, in-network and out-of-network, to use the West Virginia Health Information Network to access and share information using continuity of care documents, as well as admission,

discharge, and transfer information, which contains the minimum necessary information to coordinate care.

## Transitions from an out-of-network to in-network provider [BA27]

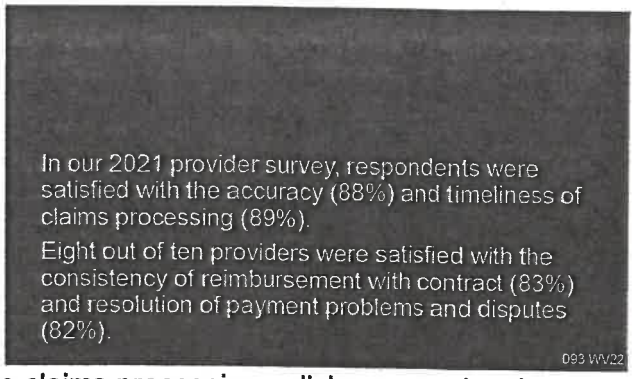
Continuity of care is especially critical for Mountain Health Promise members during times of upheaval and trauma. Aetna works with members to ensure their transition to an in-network provider is as seamless as possible. Aetna's methodology for transitioning members from an out-of-network to an in-network provider within 10 days of enrollment takes into consideration member preference, claims history, proximity, and existing relationships with PCPs or specialists. In cases where the assignment is to a PCP, we inform members they have the right to select their PCP at any time by calling member services. We are continuously building our network, and if a member requests a PCP who is not currently a participating provider, we will contact the provider to discuss the provider's interest in joining the Aetna network. If a new member does not select a PCP during initial enrollment, Aetna assigns a PCP. If a member was previously enrolled with Aetna, we auto-assign them to their previous PCP.

### Identifying an appropriate in-network provider

Aetna considers an in-network provider to be appropriate based on the member's needs, the type of provider needed, maximum travel time from the member's home, appointment availability, and wait time standards established by DHHR, so as not to disrupt the member's care. Care coordinators help members with cultural, linguistic, and gender preferences find the appropriate provider to meet their needs.

If a member does not select a PCP during the choice selection period or at the time of initial enrollment, we assign a PCP using our comprehensive rules-based PCP assignment product. This application incorporates several key functions based on the member's location, language needs, and cultural needs, as well as any prior PCP relationship. Members contact our member services department to request a PCP change or submit a PCP change request on the member portal.

## Facilitating timely payment for in- and out-of-network services [BA29]




We are committed to continuing to meet and exceed DHHR's goals for claims submission and adjudication to payment timeliness for both in and out-of-network providers. As detailed in our response to PS06, we accomplish this through focused claims inventory and workflow management practices, data monitoring and analysis, and management oversight. Aetna understands and implemented processes to comply with the DHHR's requirement to process clean claims within 30 calendar days for both in and out of network providers. Aetna has multiple claims processing policies governing the procedures for timely claims processing. These policies and procedures address: Claims Adjudication, Claims Inventory Management, Claims Submission, Provider Claim Payment and Data Completeness, as well as Out-of-Network Provider Payments. Aetna is audited annually for the effectiveness of these policies to ensure timely payment of all clean claims.

During the last 12 months Aetna's average turnaround time for Electronic Data Interchange (EDI) claims is 8 days, and our average turnaround time for paper claims is 13 days. In support of these requirements, we generate a weekly payment cycle for medical claim payments.

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## Referrals

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| BA16 | The Vendor should establish, implement, and update guidelines to be approved by the Agency for the services or types of services that can be approved by the member's primary care provider (PCP) and the services or types of services to *which the member can self-refer* for physical, oral, vision, and behavioral health services.<br>The Vendor should list the services or types of services that can be approved by the member's primary care provider (PCP). |
| BA19 | The Vendor should grant members a standing referral to a specialist provider according to guidelines that the Vendor develops, and the Agency approves, including, but not limited to, the duration and/or number of visits usually granted or maximally allowed.<br>1) The Vendor should describe the circumstances under which a member might be granted a standing referral to a specialist provider.<br>2) The Vendor should propose durations and/or number of visits usually granted or maximally allowed. |
| BA20 | The Vendor should develop and implement physical health and behavioral health guidelines to be approved by the Agency for the extent to which a specialist provider may:<br>• Admit patients for inpatient care<br>• Choose the hospital of admission<br>• Schedule or provide ancillary services, such as laboratory testing<br>• Refer patients to sub-specialists or other providers<br>The Vendor should provide proposed guidelines. |
| BA21 | The Vendor should establish and implement a process through which members and/or providers can request out-of-network referrals.<br>The Vendor should refer members to out-of-network providers using guidelines that the Vendor develops, and the Agency approves.<br>The Vendor should describe the process for members and/or providers to request out-of-network referrals. |
| BA23 | The Vendor should review and process medical referrals according to guidelines that the Vendor develops, and the Agency approves.<br>The Vendor should:<br>1) Provide proposed time frames for reviewing and processing medical referrals<br>2) Describe the average duration of medical referrals |

## Services that can be approved by the member's primary care provider or self-referred [BA16]

Aetna allows PCPs to approve any covered service, or type of covered service, that does not require PA, including physical and behavioral health specialty care and ancillary services. Aetna refers providers to its Participating Provider Prior Authorization Requirement Search Tool (ProPAT), which allows them to determine if PA is required for specific services. Providers can search up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes at a time. Aetna periodically updates it's PA guidelines through Aetna's UM Steering Committee, which makes recommendations to support improved/standardized UM processes and according to changes in West Virginia approved codes and standards.

Our annual evaluation process includes a reassessment of program structure, scope, processes, and sources used to determine benefit coverage and medical necessity. Aetna Medicaid completes a comprehensive, code-by-code reevaluations of our PA requirements annually. During our most recent review, we removed more than 135 codes from our prior authorization requirements (e.g., D9239 intravenous moderate conscious sedation / anesthesia; D9222 deep sedation / general anesthesia; A8003 hard protective custom helmet; and multiple genetic testing codes).

We also allow one home health evaluation every six months without a PA to facilitate increased access and timeliness of care. Annually, we will review additional potential changes in the authorization process for this specialized population.

We inform providers about updates to our guidelines and requirements for services that can be approved by a member's PCP or self-referral through provider workshops, fax distributions, provider manuals, and the member handbook.

### Types of services members can self-refer

**Aetna members can directly access physical, behavioral, oral, and vision covered services from any Aetna provider without referral from their PCP** (as described in the member handbook), including the following:

- Emergency services
- Primary care, dental, and oral surgery services and evaluations
- Family planning
- Maternity care, and access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within our network for women's routine and preventive health care services, in addition to direct access to a PCP for routine services, if the PCP is not a women's health specialist
- Immunizations for members 19 and over at pharmacy or health department
- Sexually transmitted disease screening, evaluation, and treatment are available from the PCP or public health departments
- Tuberculosis screening, evaluation, and treatment
- Testing for HIV, HIV-related conditions, and other communicable diseases
- Direct access to a specialist is not restricted

We educate members about covered benefits and services, our network, and member rights to choose their provider. Member education occurs during our initial contact, in-person visits, during calls to the member services hotline, and ongoing as needed. Our education always includes the member's preferences for location, provider type, and enabling services and/or accommodations.

## Standing referrals to specialists [BA19]

Aetna has an open-access network where members self-refer or directly access in-network specialty providers without notice from their PCP or prior authorization. This means all Aetna members have access to any in-network specialist, regardless of specialty or subspecialty, without limits to the duration or number of visits. We encourage all members to discuss specialty care with their PCP, who can coordinate needed services. Services must be obtained from an in-network Aetna practitioner or provider. There are exceptions to this, however; emergency, family planning, FQHC and RHC services do not require PA for in-network or out-of-network practitioners or providers. Members access these services from a qualified practitioner or provider enrolled with the State of West Virginia Medicaid program.

### Direct access for children and youth with special needs

Aetna is compliant with 42 CFR §438.208(c)(4), which requires that children and youth with special needs have direct access to specialists. Aetna provides children and youth with special needs, including members with a disabling condition or chronic illness and members who are SSI eligible, with a standing referral to an in- or out-of-network specialist or to specialty care treatment centers with expertise in treating their condition or disease. If the specialist is in-network, no PAs or referrals are required. Members who require specialized care over a prolonged period for life-threatening, degenerative, or disabling conditions are allowed a standing referral to an out-of-network specialist or

specialty care treatment centers with expertise in treating their condition or disease. This includes conditions with a complicated treatment regimen requiring ongoing monitoring of the member's adherence, such as rheumatology or neurology, and behavioral health services for members with a history of trauma or ACEs The standing referral is incorporated into the member's treatment plan.

The determination and notifications must be made within the timeframes appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed seven calendar days from the receipt of the request. If clinical information is not sufficient to determine medical necessity, UM staff make multiple attempts to obtain needed information to ensure the appropriate decision is made without delay. The process includes authorizing requests for standing referrals for members requiring more than one visit to a specialist or specialty care center for treatment of a condition. Aetna care coordinators and UM staff research a member's authorization history to avoid duplicating services the member is currently receiving or authorizations already documented in the system and authorizing services that are not in the member's benefit or treatment plan.

Recognizing the unique needs of this population, Aetna does not have standards for the durations and/or number of visits granted or maximally allowed. We review each standing referral request individually and ensure members have access to the duration and/or number of visits medically necessary to address their care needs.

## Guidelines for specialists [BA20]

When members have health conditions and needs a specialist cannot manage, Aetna allows the specialist to:

- Admit patients for inpatient care
- Choose the hospital of admission
- Schedule or provide ancillary services, such as laboratory testing
- Refer patients to sub-specialists or other providers

**If the other provider, hospital, or ancillary service is in-network, no prior authorization is required.** When access to other providers and services is limited due to geographical and demographic barriers, Aetna's care management team facilitates identification of an out-of-network provider who can meet the member's needs. If the other provider is not in our network, a PA is required for the service. We make every effort to bring these providers into our network to build capacity and enhance our ability to provide high-quality, accessible care for members. We also set up peer-to-peer physician consultations as needed to support providers and make sure members get the appropriate care they need.

### Admitting patients for inpatient care

Medical services for the treatment of an emergency condition are permitted to be delivered in or out of network without obtaining prior authorization. Aetna requires coverage of emergency services in the following situations:

- To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency condition existed
- If an authorized representative, acting for the organization, authorized the provision of emergency services
- To provide post-stabilization care services for the member

### Choosing the hospital for admission

Aetna contracts with The Joint Commission and Medicare-approved facilities that offer a full spectrum of covered services available to our West Virginia members. To make sure we have a comprehensive network to address members' needs, we monitor hospitals' specialties during the contracting process and use GeoAccess to meet time and distance requirements. GeoAccess is evaluated so that access to care requirements are met.

In the rare situation that an in-network facility is not able to meet a member's specialty health or care needs, a single case agreement will be developed for a non-network facility that can meet the member's needs.

**Members in crisis.** Through our experience, we have learned members in crisis will not be admitted to the emergency room until a hospital has capacity to serve the member. In these instances, Aetna convenes a special review, which includes the CMO, BSS caseworker, member's care manager, CCT manager, and attending hospital staff, to facilitate appropriate transfer to an available hospital for treatment. If we cannot identify an in-state hospital with bed capacity, we will identify an appropriate out-of-state hospital to see the member. The health and well-being of Mountain Health Promise members is our top priority, and we will not stop until we find a provider that can address the member's needs.

### Scheduling or providing ancillary services, such as laboratory testing

Network providers will schedule the member for ancillary care with other network providers, including network laboratory testing providers. For the convenience of our members and provider network, Aetna's network ancillary service providers are listed in our provider directory, through a searchable link on our West Virginia website, or by contacting our member services department. Additionally, upon request, our member services department assists providers to schedule ancillary service appointments for Aetna members.

### Referring members to subspecialists or other providers

When members have health care conditions and needs that cannot be managed adequately by a specialist, Aetna facilitates direct referrals to a sub-specialist by the member's specialist or PCP. Our sub-specialists are listed in the provider directory and via a searchable link on the Aetna website. When access to a sub-specialist is limited due to geographical and demographic barriers, Aetna's care management team facilitates identification of an out-of-network provider who can meet the member's needs.

We encourage providers to work with our members to select the provider or facility that will best meet their healthcare needs.

## Out-of-network referrals [BA21]

If Aetna is unable to provide necessary medical services covered under the contract within our provider network, we will coordinate these services in a timely manner with out-of-network providers, for as long as we are unable to provide the services in-network.

### Guidelines for out-of-network referrals

All out-of-network services are covered as adequately and timely as in-network services, and member costs for covered benefits are the same whether the provider is in-network or out-of-network. The member does not incur additional cost for seeking these services out of network.

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Aetna works with out-of-network providers to bring them into the network when possible and uses single case agreements requiring the provider to treat our members with the same degree of care and skill they provide to patients who are not Medicaid members. If the provider declines to contract with Aetna, the Provider Relations team will identify opportunities to fill the possible service gap via recruitment, telemedicine options, or identifying a vendor. Aetna assists members with accessing State funded transportation and room and board for out-of-network services that are out-of-state or that a member cannot access without additional support.

### Process for requesting out-of-network referrals

We educate members to contact member services or their PCP to discuss a referral to an out-of-network provider. The ordering provider must submit a PA request to Aetna for approval of out-of-network services. If we approve the request to see an out-of-network provider, Aetna covers the services. We inform members they can file an appeal if we do not approve the service authorization request. We describe the process to request out-of-network services in our provider manual and member handbook.

**In 2021, we approved 918 out-of-network service requests for Mountain Health Promise members, with an average turnaround time of 3.56 days. In the first 9 months of 2022, we approved 640 out-of-network requests with an average turnaround time of 3.4 days.**

## Reviewing and processing medical referrals [BA23]

Aetna's written policies, procedures, and workflows outline the criteria and methods we use to review and process medical referrals. The average duration of medical referrals varies, based on the type of service requested and our utilization management guidelines.

Aetna follows NCQA or West Virginia-required timelines (based on whichever is most stringent) for our decision and notification processes. Our written UM policies and procedures are in accordance with 42 CFR § 438 Subpart F, 1915(c) Waivers or State policy. Aetna consistently exceeds the required decision and notification timeframes outlined in the table below.

| Medical Referral Request Type | Proposed Timeframe for Reviewing and Processing | Average TAT *(July 2021- June 2022)* | Met TAT in 2021 |
|---|---|---|---|
| **Urgent pre-service request (including medical pharmaceuticals)** | 2 calendar days from the receipt of the request | 22 hours | 99.27% |
| **Concurrent review request** | 3 calendar days from the receipt of the request | 2 days | 99.14% |
| **Non-urgent pre-service request (including medical pharmaceuticals)** | 7 calendar days from the receipt of the request | 3 ½ days | 99.72% |
| **Post-service request** | 30 calendar days from the receipt of request | 6 days | 99.57% |

## Prior authorizations

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| BA17 | The Vendor should honor medical health, behavioral health, oral health, vision, pharmacy, and socially necessary services (SNS) authorization approvals from previous coverage during the transition period in accordance with applicable law and Appendix 3: Service Provider Agreement (SPA).<br>This is meant to include both the transition period of the program from the incumbent Vendor as well as any transition period for a new child entering the Mountain Health Promise program from fee-for-service or another Managed Care Organization (MCO).The Vendor should describe how it will meet this specification. |
| BA18 | The Vendor should notify providers and/or members regarding expiration of existing medical health, behavioral health, oral health, vision, and pharmacy (when applicable), and socially necessary services (SNS) authorizations. The Vendor should describe how it will meet this specification. |

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| BA32 | In accordance with 42 CFR §438.210(d)(2), the MCO must provide an expedited authorization for services when the provider indicates that the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The Vendor should ensure timely access to crisis stabilization services as per Appendix 3: Service Provider Contract.<br>1) The Vendor should indicate if crisis stabilization services are subject to medical necessity review criteria in compliance with the Service Provider Contract. If so, the Vendor should describe how it will make the expedited authorization decision and provide notice to the enrollee as expeditiously as the enrollee's health condition requires, but no later than two (2) business days after receipt of the request for service authorization.<br>2) The Vendor should address an approach to these services when they are provided out of network. |
| BA26 | The Vendor should apply the "prudent layperson" standard for all emergency room (ER) visits. The Vendor must pay for a member's emergency medical screening examination, as required by 42 U.S.C. 1395dd.<br>The Vendor may not require prior authorization for in-network or out-of-network services a member seeks in an emergency. Placement in an Institution for Mental Disease (IMD) is considered an emergency service and cannot require a prior authorization for the first 48 hours.<br>For more information regarding the "prudent layperson" standard, please reference Appendix 3: Service Provider Agreement (SPA).<br>The Vendor should explain:<br>1) Application of the "prudent layperson" standard for all emergency room (ER) visits<br>2) If it would not require prior authorization (PA) for screening and stabilization of members |

Prior authorization enables us to monitor utilization of defined services, procedures, and non-emergent hospitalizations before the member receives the service. For services requiring PA, we confirm services are as follows:

Aetna Better Health West Virginia achieved a 100% timely standard authorizations rate in 2021.

- Requested for eligible members
- Included in the covered benefits
- Provided at an appropriate level of care or place of service to meet the member's needs

Provided services are appropriate, timely, and cost-effective to best meet the member's needs

- Coordinated as necessary with quality management or care management, and information is communicated to applicable operations areas (e.g., finance, enrollee Services, and provider services) or per contractual requirement with external contractors
- Accurately documented to facilitate timely reimbursement and accurate reporting

## Honoring authorizations from during transitions [BA17]

Aetna's member transition process works to ensure members' care continues without interruption or delay during the transition of moving from one MCO to another, from a different program into Mountain Health Promise, from FFS to an MCO, or from private insurance to an MCO. **To maintain continuity and quality of care, Aetna will honor authorization approvals during these key transitions.** This includes honoring previous authorizations for members' holistic needs, including medical, behavioral, and oral health; vision; pharmacy; and social necessary services (SNS).

**Supporting successful transitions.** We provide initial and ongoing staff trainings and conduct internal audits to ensure our member-facing staff are well informed on covered benefits and regulations so they can assist these members in understanding and adjusting to processes around member concerns, provider selection, prior authorization, or any information which is unfamiliar to them.

### Physical, behavioral health, dental, and vision services

Aetna's standard transition of care procedures include honoring existing PH, behavioral health, dental, and vision authorizations for 90 days, or until the current treatment is completed (e.g., supporting a pregnant mother through the delivery of her child or a member in treatment for cancer). This helps to assure continuity of care by honoring previously established therapeutic relationships for our members. Our local staff are focused on our members and providers and the quality of their experience with us. When members transition to Aetna from another MCO, private insurance, or FFS, they are identified or otherwise flagged in our informatics system. This allows utilization management staff to identify current authorized services that should be continued during the transition period to support continuity of care.

### Pharmacy

We support member transitions from previous coverage by providing access or ensuring access to covered medications consistent with state requirements by ensuring availability of 2 fills of a medication up to a 34-day total transition supply within 90 days from the date the member becomes eligible with Aetna. We ensure continuity of care for new members on protected medications by providing access to the medication if the prescriber writes for the medication. For members stabilized on any medication during an inpatient hospital stay, Aetna ensures access to the medication if medically necessary, as determined by the prescriber's written prescription and plan of therapy. Aetna understands each member's experience is unique and we work directly with our members to assure their medications and treatments are not interrupted with any of their transitions.

### Socially necessary services

Aetna holds the statewide SNS contract in West Virginia for all service categories (e.g., family preservation, foster care, reunification, adoption preservation). If a member receives SNS authorizations prior to coming into West Virginia foster care, Aetna, in collaboration with Kepro, will honor these authorizations.

Aetna has successfully collaborated with Kepro to manage SNS authorizations and ensure undisrupted access to these services and supports since 2020. We will continue this collaboration, offering a seamless experience to SNS providers.

## Notifying members and providers when authorizations expire [BA18]

Aetna's care management system, aligned with our authorization system, tracks all physical health, behavioral health, dental, and vision authorization expiration dates. The care coordinator will contact the member/family by telephone, or arrange a face-to-face contact, to explain the expiration and discuss potential continued need and potential reauthorization.

Care management staff are automatically alerted when an SNS authorization is going to expire within 30 days. Kepro staff also inform the provider concerned and Agency caseworker (via fax or email) informing them of the expiration date of the SNS authorization. Providers are informed to submit a new authorization request 10 days prior to the SNS expiration if services are to continue beyond the expiration date of the current authorization.

## Immediate access to crisis stabilization [BA32]

Aetna's behavioral health crisis system includes mobile crisis, facility-based crisis, inpatient services, ED services, State facility services, and other providers. Aetna has contracts with most hospitals in the State and several of the other crisis providers, including mobile crisis. In addition, our Recovery and Resiliency Administrator works with all SUD stakeholders to integrate and collaborate on both a system

and member level, including crisis services. **Prior authorization is not required for emergency or crisis stabilization services.**

**Behavioral health crisis calls:** A live behavioral health Crisis Services hotline staff member answers our 24/7/365 behavioral health crisis calls immediately—we never answer behavioral health crisis calls through an automated call system. The behavioral health Crisis Services hotline staff begin to stabilize the crisis by assessing, screening, and triaging through telephonic crisis intervention to make sure the member is safe. This staff coordinates the most appropriate level of care needed, including hospital-based ER services, mobile crisis unit services, face-to-face stabilization services, or other care. Our behavioral health Crisis Services hotline received 200 calls in 2021, connecting all members to appropriate behavioral health services.

**Enhanced mobile crisis services through 844-Help4WV:** Families of children and youth in a crisis can call the Children's Crisis and Referral Line to be connected to regional Mobile Crisis Response and Stabilization Teams for over-the-phone or in-person crisis de-escalation support. Members have 24/7/365 access to 844-Help4WV's crisis and non-emergency behavioral health and substance use services via calls, texts, online chats, or emails.

Following a mobile crisis intervention, Aetna works with behavioral health facilities to coordinate necessary outpatient services with the child's guardian to provide the following services:

- Conduct risk assessments, provide crisis interventions, and connect the individual to ongoing behavioral health services or other community resources/supports
- Provide crisis services of triage, assessment,
- and immediate stabilization of acute symptoms of mental illness, substance use, and emotional distress
- Make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs
- Assist and transport the individual to a more appropriate facility for further care, if clinically indicated
- Provide two-person mobile teams—with at least behavioral health technician (behavioral health) level crisis workers
- Engage peer and family support services as preferred and identified by the member and Agency caseworker
- Assist the individual to utilize community and family/support systems with the intent of preventing the reoccurrence of similar events in the future

### Crisis stabilization services from out-of-network providers

Aetna covers a member's out-of-network hospital fees until the member's records, clinical information, and care can be transferred to a network hospital, no longer meets medical necessity for continued hospitalization, or until such time as the member is discharged, whichever is shorter for:

- Medically necessary admissions resulting from out-of-network emergency services
- Medically necessary acute care after an out-of-network emergency room visit

Aetna informs our members that emergency care is available 24/7/365, at the nearest facility available, regardless of the emergency room's provider participation status. Aetna covers services for emergency transportation by ambulance for emergency medical conditions.

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## Application of prudent layperson standard for emergency room visits [BA26]

**Aetna never requires prior authorization for emergency care,** and we follow the prudent layperson standard for all ED visits.

We permit the delivery of PH and behavioral health services for the treatment of emergency conditions in-network or out-of-network **without Prior Authorization** in the following situations:

- Screen and stabilize the member when a medical practitioner deems emergency services are required
- Physician determines the member's life will be endangered or other serious injury could occur if the member is discharged and/or treatment is delayed
- Delay or lack of treatment would subject the member to severe pain that cannot be adequately managed without the health care service or treatment being requested
- Service or treatment of an SUD or co-occurring mental health disorder within a partial hospitalization program or crisis stabilization unit needed to keep a member from requiring inpatient services

Aetna's written and detailed UM policies and procures for emergency services and post-stabilization adhere to 42 CFR § 438.114(e) and 42 CFR § 422.113(c). They are reviewed annually and revised more frequently should changes be necessary based on State or federal language.

## Utilization management guidelines

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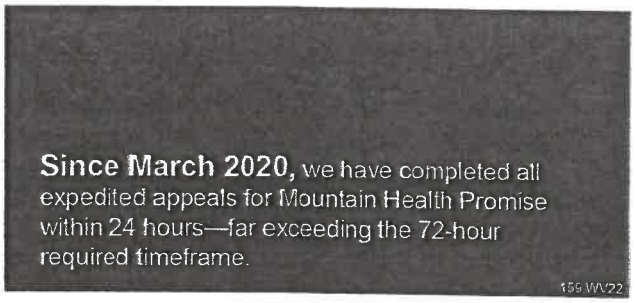
| BA10 | The Vendor should develop, review, and apply utilization management guidelines to be approved by the Agency for medical health, behavioral health, oral health, vision, pharmacy (when applicable), and socially necessary services (SNS). The Vendor should apply its utilization management guidelines to retroactively review payments for physical and behavioral health payments.<br>The Vendor should establish utilization management processes for members, including, but not limited to, the following:<br>• Medical necessity review<br>• Social necessity review<br>• Approvals<br>• Denials<br>Per Appendix 3: Service Provider Agreement (SPA), all utilization guidelines must meet Department of Health and Human Resources (DHHR) specified standards for utilization management.<br>1) The Vendor should describe its process to develop and revise physical health and behavioral health services utilization management guidelines.<br>2) The Vendor should provide proposed physical and behavioral health utilization management guidelines that reflect an understanding of this contract's population, services, and stakeholders.<br>3) The Vendor should describe its process to retroactively review payments or services for physical and behavioral health.<br>4) The Vendor should describe how its utilization management processes support members, both for the processes listed and any other processes the Vendor identifies as supporting members.<br>Note: See Appendix 9: SNS Utilization Management Guide for more information on current socially necessary services (SNS) utilization management guidelines. |
| BA15 | The Vendor should modify its standard utilization management protocols by establishing condition-specific protocols when reviewing referral and treatment requests for members with special healthcare needs, including, but not limited to, standing referrals and expedited utilization review processes.<br>The Vendor should share condition-specific protocols or standards with primary and specialty care providers as part of their ongoing training with providers.<br>The Vendor should:<br>1) Identify factors that may require modification of its standard utilization management protocols<br>2) Give at least one example of each factor and describe how the standard protocols would be changed as a result |

Aetna's utilization management program advances whole-person care through identifying, evaluating, managing, and improving clinical care, services, and supports provided to our members. Our primary focus is to promote delivery of high-quality and cost-effective care to our members while managing utilization of services. Our program protocols consider individual member characteristics, unmet health care and social needs, and demographics. The scope of our UM program spans all clinical aspects of health: physical health including preventive, diagnostic, oral health, and treatment services in inpatient, outpatient, and homebased treatment settings; behavioral health; and the full set of socio-economic factors that impact health. As an **NCQA-accredited health plan with a 4-STAR rating**, we continually monitor our processes, policies, and procedures through audits. We conduct an annual review of policies and procedures, which the Policy and Procedure Committee reviews and approves.

## Utilization management processes for members [BA10]

Aetna uses nationally recognized, evidence-based criteria (e.g., Milliman Care Guidelines (MCG) that is applied based on the needs of individual members and characteristics of the local delivery system. Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. Criteria sets are reviewed annually for appropriateness and applicability for West Virginia's children and youth involved in child welfare. We modify criteria as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate physical health and behavioral health medical directors, pharmacists, and practitioners in developing, adopting, or reviewing criteria. We advise members and providers that criteria are available upon request and free of charge in the Notice of Action and the provider manual.

**Medical necessity review.** We conduct comprehensive training for staff who make medical necessity determinations to ensure consistency of reviews. Provider services and utilization management staff are available to answer questions and provide guidance on the use of clinical guidelines and utilization management requirements. Aetna proactively educates our members and our provider community about the basis for use and the content of the guidelines. We also offer targeted education to care coordinators about SNS UM guidelines to facilitate the authorization of the most appropriate provider, scope, and duration of the requested service, based on the individual member needs. This step has helped to remove any access to care issues involved in the required administrative processes.




**Social necessity review.** Kepro reviews SNS, according to the West Virginia requirements and guidelines. Each case is reviewed according to the individual request by specially trained staff on social services. The Aetna SNS team, that includes Kepro, reviews SNS requests and provides support to bureau staff. Aetna notifies DHHR if any problems are found with a provider either in their UM practices or retrospective reviews. We also collaborate with Agency caseworkers if we identify access issues or if there is a more appropriate service or provider available for consideration by the child/youth's MDT.

**Approvals.** Aetna makes PA decisions and notifies practitioners and/or providers and members, as applicable, in accordance with the Model Purchase of SPA. Aetna uses the strictest or shortest timeframe to assure compliance with all requirements and in the best interest of the member. Aetna follows NCQA or State-required timelines (based on which is most stringent) for our decision and

notification. Our written UM policies and procedures are in accordance with 42 CFR § 438 Subpart F, 1915(c) Waivers or State policy.

**Denials.** Aetna provides the primary practitioner/provider(s) and member with electronic/written notification of any decision to in whole or part deny, reduce, suspend, or terminate a service authorization request, or to limit or authorize a service in an amount, duration or scope that is less than requested. The notification includes information on how to obtain criteria used to make the decision as well as member appeal rights, provider appeal rights, and how providers can contact Aetna to request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer.

Aetna has processes to provide the member's PCP with electronic/written notification of adverse benefit determinations to facilitate care coordination, to assure the PH and behavioral health needs of members are identified, and that services are facilitated and coordinated with all service providers, individual members, and their family, if appropriate, and authorized by the member or their guardian.

Our Notice of Action process complies with 42 CFR 438.404 including timeframes for the notice and notice contents. Following an initial decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, we send written notice to the member and provider. Our notice is on DHHR required template and is thoroughly completed in easily understandable language, and includes all required information detailed in 42 CFR 431.210.

### Developing and revising physical health and behavioral health guidelines

Aetna uses nationally recognized evidence-based criteria in our UM guidelines, which are applied based on the needs of individual members and characteristics of the local delivery system to align with DHHR's clinical coverage policies. Our utilization management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. We review clinical criteria sets for adoption per award, and then review and update them annually or as applicable when national or community evidence-based clinical criteria guidelines are released or revised. The annual review process involves a broad range of specialties such as emergency medicine, behavioral health, pediatrics, surgery, family medicine, internal medicine, and a pharmacist, in developing, adopting, and reviewing criteria. Aetna ensures that the clinical criteria sets are sufficient to address the services necessary for diagnosis or treatment of illness or injury, to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth and development. We advise providers that criteria are available upon request, in the notice of adverse benefit determination, and via provider webinars, email/fax distributions, face-to-face visit with providers, and the provider manual. We advise members that criteria is available upon request and free of charge by contacting the member services department, in the notice of adverse benefit determination, and in the member handbook.

Formal medical committees and ad hoc workgroups advise and guide the development and adoption of guidelines. Aetna develops clinical criteria policies using peer-reviewed medical literature, technology assessments, structured evidence reviews, evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies. Aetna reviews clinical criteria policies annually or more frequently based on knowledge of relevant new medical literature, guidelines, and regulatory action notices. Aetna's Clinical Policy Council Committee and external practicing clinicians with expertise in providing the types of services in the clinical criteria policies conduct a comprehensive review process of both new and revised policies.

## Proposed physical and behavioral health guidelines that reflect the population, services, and stakeholders

Aetna uses the following nationally recognized, peer-reviewed, evidence-based criteria for physical health, behavioral health, and medical pharmaceuticals, consulted in the order listed; as applicable:

- State, federal, or regulatory agency
- Aetna pharmacy guidelines
- MCG (physical health and behavioral health)
- Level of Care Utilization System (LOCUS) and Child & Adolescent Level of Care Utilization System (CALOCUS)
- ASAM
- Aetna Clinical Policy Bulletins (CPB)
- Aetna Clinical Policy Council Review
- Other specialty criteria by contract, such as CAFAS for level of care reviews

**These physical and behavioral health guidelines are adopted to promote consistent application of treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care across all populations.** Aetna communicates changes and updates to clinical practice guidelines, MCG, Aetna CPB, and PA requirements through provider forums, fax distributions, provider letters, and regular and ad hoc meetings by network account management. They are also reviewed and approved by the Quality Management and Utilization Management Committees in which providers participate.

**Mental health parity.** Aetna demonstrated compliance with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K in West Virginia. Through our initiation of activities to comply with these acts in 2008, we have conducted review of, and implemented, clinical authorization guidelines for physical and behavioral health. As a result, our processes and systems fully comply with the act. The treatment limitations we apply to mental health and SUD benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by Aetna. Additionally, there are no separate treatment limitations applicable to mental health or SUD benefits. Aetna provider agreements require provider compliance with the Mental Health Parity and Addiction Equity Act.

## Retroactively reviewing physical and behavioral health payments or services

Reimbursement for services are determined retrospectively (e.g., we receive notification of a hospitalization after the member's discharge or for members who receive retroactive Medicaid eligibility). We base our retrospective reviews solely on the medical information available to the attending physician or ordering provider at the time the member received health care services. We review retrospective determinations utilizing the same criteria as concurrent determinations for the same service. We communicate retrospective review decisions to the requesting practitioner/provider and the member, if applicable, within 30 calendar days of receipt of the request.

## Aetna's utilization management processes support members

Due to the complex and special needs of the children and families we serve, we recognize there are instances where members have extenuating circumstances that require an individualized approach. We evaluate services and supports on a case-by-case basis; considering history of trauma, stability of

current placement, and other social and emotional needs to ensure each member receives the care required to meet those needs. For example, **on numerous occasions, our CMO has outreached to the State Medicaid medical director to align our approach with state goals for complex care.** We collaborate with stakeholders, providers, and community organizations to collect and assess clinical data to complete the medical necessity review. For example, an instance was presented that a member needed a non-covered glucose monitoring system and insulin pump, and through discussions with Aetna's CMO and the State Medicaid medical director, it was agreed Aetna would cover this due to the member's complex health needs.

## Modifying protocols for members with special healthcare needs [BA15]

Aetna modifies its standard UM protocols when reviewing referral and treatment

requests for members with special healthcare needs. Factors that require modification of standard UM protocols include, but are not limited to, the following:

- Benefit limits:
  - Lifetime benefit: e.g., for members in need of orthopedic braces due to scoliosis or spina bifida, exceptions to lifetime benefit limits can be made to allow for new braces as the child grows
  - Benefit exceptions for therapeutic services: e.g., for members with developmental delays in need of physical therapy, occupational therapy, or speech therapy, Aetna makes exceptions to benefit limits for therapeutic services
- **Time limit exceptions:** e.g., for members in the course of ongoing treatment, Aetna makes exceptions to time limits on benefits during the transition phase to make sure members' treatment is completed
- **EPSDT**: e.g., any service requested under EPSDT that is not covered as a Medicaid benefit can be covered if it meets EPSDT criteria, including EPSDT specialized services
- **Medical foods:** e.g., for members with feeding difficulties who require special medical foods otherwise not covered through Women, Infants, and Children (WIC) benefits, Aetna makes exceptions to assure their nutritional needs are met. For example, a 10-year-old Aetna member has a chronic gastrointestinal condition that requires tube feedings (enteral) to meet the daily caloric requirements to sustain a healthy weight. Although not covered through the Mountain Health Promise program, Aetna covers all liquid foods for members receiving tube feedings.




Aetna provides ongoing education to primary and specialty providers about its condition-specific standards through provider workshops and provider fax distributions. Our provider services representatives also educate providers about condition-specific standards during in-office visits and through telephonic provider inquiries.

### Standing referrals for members with special healthcare needs

As detailed in BA19, Aetna is compliant with 42 CFR §438.208(c)(4), which requires children and youth with special needs have direct access to specialists. Aetna members who require specialized care over a prolonged period for a life-threatening, degenerative, or disabling condition are allowed a standing

referral to a specialist or specialty care treatment centers with expertise in treating the condition or disease.

Determinations and notifications must be made within the timeframes appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed seven calendar days from the receipt of the request. The process includes authorizing requests for standing referrals for members requiring more than one visit to a specialist or specialty care center for treatment of a condition. Aetna care coordinators will research a member's authorization history to avoid the following:

- Duplicating services the member is already receiving
- Authorizing services that are not in the member's benefit plan or treatment plan
- Duplicating authorizations already documented in the system

**Expedited review process**. Aetna offers an expedited review process within 48 hours if the member's condition or health need:

- Seriously jeopardizes the life or health of the member
- Jeopardizes the member's ability to regain maximum function
- Subjects the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

## Utilization Monitoring

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| BA14 | The Vendor should operate utilization management monitoring activities in conjunction with fraud and abuse detection activities to include, but not be limited to, pharmacy services.<br>The Vendor should describe how it will meet this specification. |
| BA25 | The Vendor should perform ongoing monitoring of emergency room (ER) usage, including but not limited to, identifying non-emergent use of the ER. The Vendor should address inappropriate ER utilization through methods that include, but are not limited to, education on urgent and emergent care utilization, removing barriers to care, and assisting the member to access routine and urgent care services care.<br>The Vendor should describe the method(s) it will utilize for ongoing monitoring of emergency room (ER) usage.<br>The Vendor should also focus on what methods it will use to address inappropriate ER utilization. |

Aetna is a national leader in health care and pharmacy fraud, waste, and abuse (FWA) prevention and detection. Our multi-faceted approach includes monitoring claims data and application of algorithms to proactively identify outliers. For example:

- **Urine drug screens**: As part of our ongoing monitoring of Aetna claims data, we discovered a spike in claims payments for urine drug screens. Upon closer investigation, we found that select providers were billing for weekly complex urine drug screens that were not medically necessary. Working with the State, we developed guidelines and limitations on urine drug screens, which align with the ASAM Consensus Statement Appropriate Use of Drug Testing in Clinical Addiction Medicine. This resulted in a dramatic decrease in high complexity urine drug screens across the state and across all West Virginia Medicaid MCOs.
- **ER level of care**: Aetna reviews ER levels of care for all billing hospitals. Through this review, we identified a rural West Virginia hospital that was billing 100% of claims at Level 5 (most complex). To resolve this, we implemented a pre-payment medical record review approach to ensure appropriate level of care billing, which resulted in the normalization of appropriate level of care claims submissions. Our Provider Relations outreached the hospital to present the provider with education on appropriate ER level of care guidelines.

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## Utilization management monitoring supports fraud and abuse detection [BA14]

Aetna uses UM guidelines, policies, and data for monitoring utilization and deviations from quality-of-care standards as the foundation for FWA prevention and detection activities in West Virginia. At Aetna, preventing and detecting fraud and abuse is everyone's job. All staff are trained in detecting and preventing FWA, and staff forward their concerns to the Special Investigation Unit (SIU), which is the hub for all FWA activities. Information exchange between UM and SIU is key to ensuring vigilance in fraud and abuse detection. **Our efforts to detect and prevent FWA have been successful: in 2021, we had $2,369,753 in savings, year to date in 2022, our savings have been $1,919,943.**

### Peer Support Services for Members with SUD

Through recurring utilization management monitoring and claims reviews, we identified overutilization of peer support services. Our analysis indicated that providers were billing for activities that did not meet the State's definition for peer support. In collaboration with the State, we clarified the existing guidelines, educated providers regarding the type of activities qualify as Peer Support definition and the appropriate documentation needed to support these claims. Aetna Better Health was invited to present on this topic at the 2022 West Virginia Peer Recovery Support Services conference.

When appropriate, Aetna modifies our Medical Management policies to address emerging schemes and trends. Aetna processes and guidelines encompass three types of reviews:

- **Prospective review** includes the review of medical necessity for the performance of services or scheduled procedures. PA evaluation is based on state contract/manual requirements and then MCG national standards and guidelines. PA processes detect and prevent FWA by setting guidelines and limits requiring medical necessity prior to services being performed.
- **Concurrent review** includes review of medical necessity decisions made while the member is currently in an acute, sub-acute (RMHTF), rehabilitation, SUD residential, partial hospitalization (behavioral health only), intensive outpatient, crisis stabilization unit, post-acute, and observation (out-of-network only) setting. Evaluation of decision-making in documentation reviews that use Aetna Clinical Policy Guidelines, long-term treatment plans and programs, and peer evaluation of treatment plans and protocols resulting in an eagle's-eye view of peer-to-peer outliers of treatment behaviors that can be considered FWA.
- **Retrospective review** involves a review of coverage after treatment is provided and data analysis of peer outliers across the network. This includes national schemes and trends.

**Utilizing an interdisciplinary team approach.** Our QM, provider services, pharmacy, and SIU departments work with the UM department to identify, track, and address over-utilization and under-utilization and to identify solutions and/or resolve FWA within the provider community. Our UM/QM Committee reviews West Virginia UM reports and dashboards weekly. In utilization trend meetings, UM clinical staff look at patterns of usage for spikes to identify outliers in services, supplies, and prescription medications. Aetna's SIU analytics group runs case- and scheme-specific reports using Structured Query Language, Statistical Analysis System software, and Crystal reporting technology to support current investigations and identify new cases. The SIU performs on going reviews of the plan to identify high-dollar specialties, high utilization providers, and procedures codes. These ongoing reviews suggest to the SIU investigators which specialties/providers/codes to review for outlier behavior which is indicative of FWA.

In addition, on a quarterly basis, the SIU analytics group runs a minimum of 25 outlier reports of known categories of fraudulent schemes, such as up-coding, double billing, and billing for services that were not provided, based on specialty and current procedure terminology codes to identify the top providers of certain services. For example, services related to home- and community-based health care, DME, and physical therapy are at high risk for fraudulent behavior and are among the quarterly report presented to the plan investigators. The medical management director, CMO or medical director, and behavioral health medical director attend monthly meetings where these reports are discussed and broken out for further investigation. The CMO or medical director and SIU senior investigator meet monthly to discuss current cases and additional projects derived from the Code Team (an interdepartmental team of Operations and Medical Management staff which meets monthly to review code changes), UM analysis, and the SIU quarterly data mining. Aetna also identifies and distributes national trends in utilization, such as codes that are being abused in other states.

Aetna's SIU data mining is enhanced by Healthcare Fraud Shield (HCFS), a platform that comes equipped with approximately 600 health care business rules and algorithms maintained and updated quarterly. HCFS business rules and algorithms are customizable at the health plan level to account for benefit variations and can be applied pre- and post-payment. This platform identifies providers with potential FWA behaviors and assigns them a risk score. Aetna's SIU uses the HCFS application screens to visualize all FWA leads and provider billing activity as well as download the past 12 months' worth of claims for each lead. This helps Aetna's SIU further avoid inappropriate billing, identifies, and mitigates provider abrasion, and deters criminal activities, among others key FWA concepts. Current HCFS customers report returns from $3 to $10 for every dollar invested.

**Monitoring pharmacy services.** The Aetna pharmacy team conducts activities, including routine audits, to prevent and detect FWA through the review of pharmacy claims (made available from the state of West Virginia). The Aetna pharmacy team runs monthly and quarterly reports such as: Top Member with over $5,000 in prescription spend, Top Pharmacy by cost and prescription utilization, and Top Prescribers by pharmacy cost and prescription volume to identify members, pharmacies, and prescribers of concern and shares that information with appropriate care management, medical management, utilization and quality management, and compliance team members to take next steps.

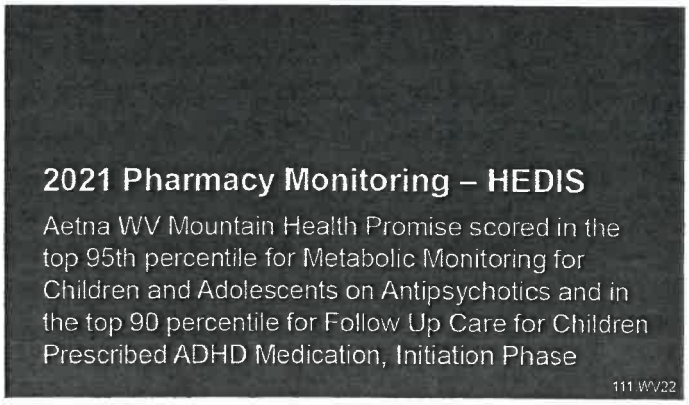
- Aetna's drug utilization review (DUR) approach to managing inappropriate utilization of controlled prescription medications is collaborative and member-centered. Our approach decreases fragmentation and increases integration across providers and care settings thus minimizing unsafe medication use. Programs led by our pharmacy director under the guidance of our CMO or medical director foster collaboration among community-based retail pharmacists and Aetna care management and medical services teams when working with members identified with DUR opportunities. Aetna's clinical pharmacy staff, using information on medication use and prescribing from multiple sources, works closely with our care management and QM departments to exchange ideas to improve member and provider access and use of medications. Aetna applies our DUR tools to assess member and provider opioid utilization patterns and drive development and implementation of interventions and educational programs. For example, our Children's Healthy Medication and Monitoring Program (CHAMMP) targets inappropriate prescribing and polypharmacy among the child population, including children in foster care, including but not limited to:
- Using internal polypharmacy report to identify high-risk members

- Implementing internal polypharmacy rounds with care management staff, quality management, utilization management staff, pharmacy staff, Aetna medical directors, and DHHR partners to resolve medication-related issues
- Referring members to a Clinical Pharmacy Advisor (CPA) for consultation as part of Pharmacy Medication Management Program (PMMP)
- Educating members providers about polypharmacy

The CHAMMP program was implemented for Mountain Health Promise members in August 2022. **Our affiliate health plan in Kentucky, saw a 50% reduction of members who met criteria for psychotropic polypharmacy in its first year of the program.**

Utilization management staff review data to identify potential deviations from accepted standards of care to determine if care complies with Aetna's standards of medical care and to ensure members are receiving appropriate and effective care. Data sources include member complaints, such as inappropriate treatments or poor outcomes of care.

Aetna also develops FWA educational programs for members and providers in the State that include member and provider newsletters, and information on both our member and provider websites and handbooks.




## Ongoing monitoring of emergency room utilization [BA25]

Aetna's approach to monitoring ER utilization involves close collaboration between care management and UM staff and utilizes a variety of modalities, including near real-time data feeds and a geographic and demographic dashboard. We share ER utilization data through our population health information platform and work with providers through value-based purchasing agreements. We communicate ER visits with our internal service coordinators, home care providers, PCPs, and specialty providers and work with hospitals to identify members with medium or high risk of returning to the ER so we can contact members during and after discharge to assess needs and create follow up plans. Ongoing ER monitoring and ER data sharing methods include:

**Admission, discharge, and transfer (ADT) feeds**: We currently receive ADT feeds, daily, from PreManage via Collective Medical Technologies (CMT) and the West Virginia Health Information Network (WVHIN) into our population health platform and share the information with our providers in **near real-time**. We will continue to work with the state on clinically integrating data to reduce barriers for our members.

**Population health management platform**: Aetna makes ADT information from PreManage via CMT and WVHIN available to providers through our electronic population health management platform.

**ER utilization dashboard:** This dashboard as shown in Figure 1.1-4 allows Aetna staff to monitor ER utilization data through demographic and health equity lenses. The dashboard sorts and filters member ER utilization data to identify possible demographic-related disparities related to race, ethnicity, language, geography, or adverse incidents. We map where high ER utilizers reside, which allows us to assess local hospitals, urgent care centers, and providers with after-hours care to assist members with

finding appropriate, available services when possible. This provides for a region-specific, targeted approach to ER diversion through data identification and clarification of existing inequities. For example, if we identify a county that is an outlier for high ER utilization, we conduct a network analysis to confirm adequate access. Depending on this analysis, we incentivize after-hours care, as well as conduct targeted member and provider outreach and education to facilitate appropriate utilization.

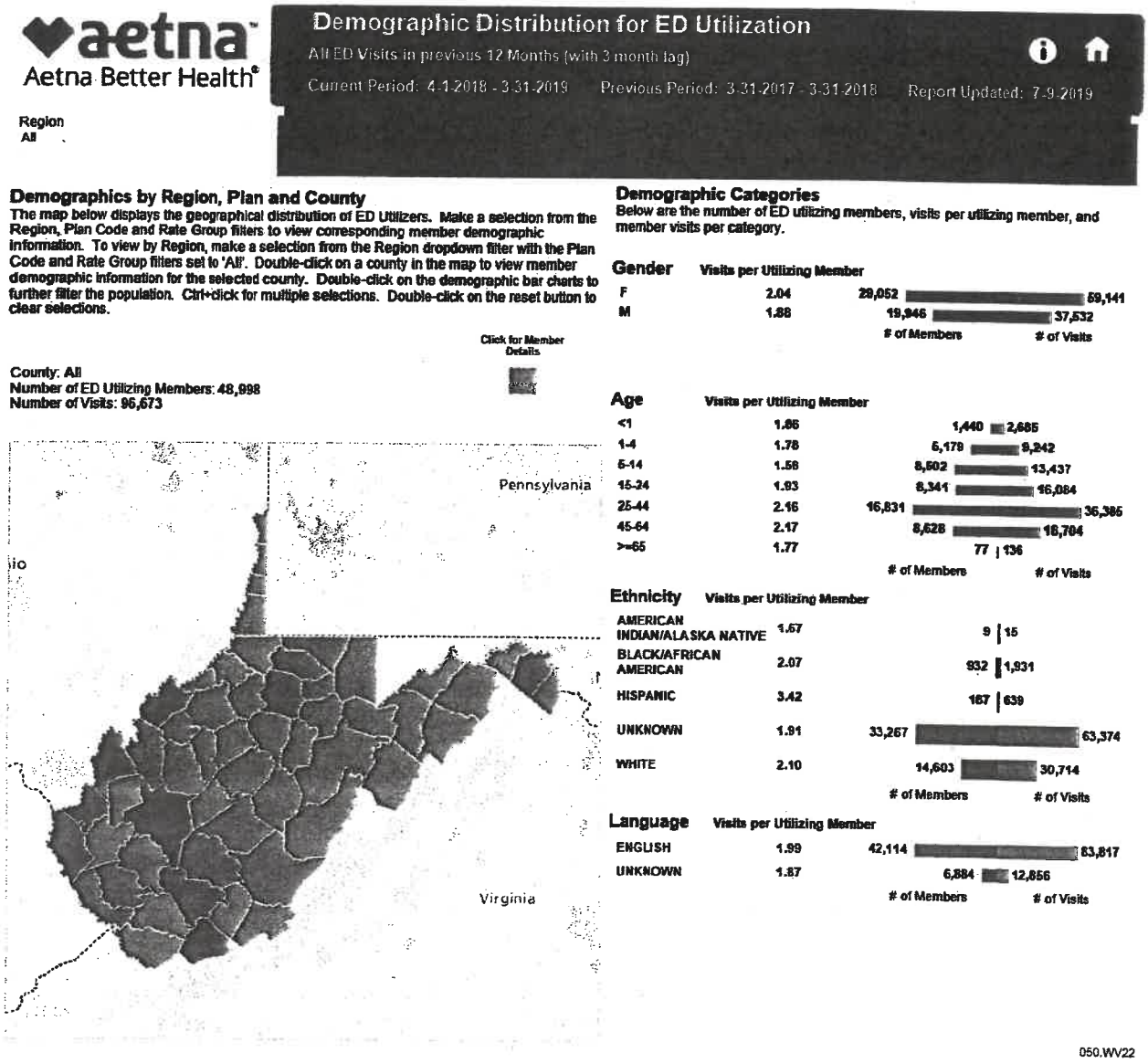



***Figure 1.1-4: Demographic distribution for emergency services utilization dashboard*** *- Aetna uses emergency services utilization data from this dashboard to identify possible demographic-related disparities for a region-specific, targeted approach to ER diversion.*

## Preventing and addressing inappropriate ER utilization

As further detailed in our care management responses, Aetna uses screenings, assessments, and comprehensive risk stratification modalities to identify members and families at risk for, or historically engaging in avoidable or inappropriate ER utilization. As these members are identified, our CCT conducts timely and proactive outreach using an evidence-based Next Best Action process, to provide individualized solutions and education on how to access care appropriate to their meet needs, including preventive and after-hours care. Our CCT also outreaches to the member's PCP to collaborate on and

support member outreach and access to preventive care. We supplement this individualized outreach by educating members about appropriate utilization through the member handbook and newsletters.

Aetna takes actives measures to prevent inappropriate ER utilization by the implementation of the following:

- **CHWs and peer support specialist services (PSS):** Aetna's community-based CHWs and PSSs address the member's SDoH needs by coordinating with community-based organizations to refer members to appropriate services and resolve social needs that can worsen health or increase avoidable ER visits.
- **Health information line:** Aetna members have 24/7/365 access to our Health Information line (Nurse Line) and Behavioral Health Crisis Services hotline. Through these resources, members receive recommendations, in the language of their preference, on their health care issues. Nurses who staff the Health Information line instruct members on self-care options, refer them to their PCPs for follow-up, or recommend a visit to urgent care, helping to prevent avoidable ER visits.
- **Alternative payment models** (APMs). Our pay-for-quality and Patient Centered Medical Home APM contracts allow providers to earn specified payments when their ambulatory ER rate per 1,000 members does not exceed the predetermined target.
- **Identifying Access Issues.** Our CCT collaborates with our provider network and services teams to identify whether the inappropriate use is related to member access issues through:
- Direct member and caregiver outreach
- Ongoing network adequacy and access monitoring
- Analysis of barriers related to SDoH, such as transportation, childcare, food, and shelter

PCPs are contractually required to offer 24/7 access to care, including after-hours, holiday, and weekend care. The PCP directs a patient to seek care at an emergency facility, give a recommendation, and prescribe treatments or medications until the member can visit the PCP office. If a provider is not offering adequate after-hours access or timely appointments, our provider services representative will outreach to that provider, offer education and reminders about this contractual obligation, or take other actions to remediate any access issues.

**Addressing inappropriate ER utilization.** Aetna uses a comprehensive approach to mitigate members' inappropriate ER utilization related to access to care issues including:

- Ensuring members have access to an urgent care center and providing member education about appropriate use of an urgent care center (versus the ER)
- Ongoing network development to increase access to preventive care
- Assisting members with appointment scheduling and transportation to and from preventive care visits

As part of our comprehensive network offering, we support members in their homes and communities by **offering telemedicine services through our existing network** in place with contracted FQHCs, and CMHC's throughout the state. Additionally, we collaborate with West Virginia University Medicine Children's Hospital to offer a web-based solution, enabling members to access outpatient services from the convenience of their community. We also contract with Marshall University to provide access to board-certified maternal-fetal medicine specialists for women experiencing high-risk pregnancies via telemedicine.

**Since the development of our care connection teams and ER utilization management program, we have significantly reduced ER utilization with a 17% decrease in 2021 and 18% decrease in 2020.**

## Utilization management systems

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| BA11 | The Vendor should leverage a utilization management system with the ability to include text fields, including, but not limited to, the following:<br>• Clinical notes<br>• Inpatient requests<br>• Review criteria<br>• Case history<br>The Vendor should:<br>1) Describe and/or visually depict the system it would leverage for utilization management services<br>2) Describe that system's ability to include the requested text field |
| BA12 | The Vendor should leverage a utilization management system with the ability to support claims payment for physical, oral, vision, and behavioral health services and inbound member and provider inquiries by interfacing with other Vendor systems, as applicable, and Agency enterprise systems, including, but not limited to, Medicaid Management Information System (MMIS) and call center. The Vendor should have the flexibility to interface with new systems as they are added to the State's Medicaid Enterprise System (MES).<br>The Vendor should:<br>1) Describe its utilization management system's ability to support claims payment for physical and behavioral health services<br>2) Identify necessary interfaces<br>3) Describe its utilization management system's ability to support inbound member and provider inquiries |
| BA13 | The Vendor should establish interface(s) and conduct testing that meets all Agency-specified interface requirements, including, but not limited to, the following:<br>• Medicaid Management Information System (MMIS)<br>• Families and Children Tracking System (FACTS)<br>• People's Access to Health (PATH)<br>• All additional systems added to the State's Medicaid Enterprise System (MES)<br>This includes, but is not limited to, sending and receiving of Electronic Data Interchange (EDI) which includes the submission of encounter data claims and the receipt of eligibility data.<br>The Vendor should describe how it will meet this specification. |

Aetna's robust, integrated MIS supports the both the member and provider journey and increases service efficiency and effectiveness. Our HIPAA- and 42 CFR-compliant MIS platform provides rules-based eligibility, enrollment, customer service, claims processing systems, and web-based care management applications that serve individuals and providers. Our national robust expertise, resources, and innovative data solutions helps solidify a member care experience that is effective, seamless, and personalized to their individual needs while supporting providers to help them achieve success in meeting their quality and cost outcomes.

Our systems and processes allow exchange of data with providers of all types, including SNS providers. We are a leader in utilizing the WVHIN and ADT feeds from PreManage via CMT to increase the exchange of data between our UM application and health care providers to foster innovative, quality, member-centered health outcomes. All stakeholders benefit from ready access to local, dedicated, and comprehensive MIS staff expertise. Our Aetna-designated MIS personnel participate regularly in DHHR's MIS calls and other MIS-related work groups (i.e., encounters and technology calls). They adhere to DHHR's policies and procedures regarding advance notification of major systems changes and implementations, and communication of changes within the MIS organization structure with prompt updates to point-of-contact information.

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## Utilization management system with customized text fields [BA11]

Our utilization management application integrates systems for reviewing, managing, monitoring, evaluating, and improving the utilization of the care and services our members receive, including those provided by subcontractors (e.g., eviCore for pain management and complex radiology authorizations).

It houses **all clinical notes** related to a member's care; **requests for inpatient treatment**; and a **complete case history**. Our teams use this application to help members and providers use appropriate care and service delivery systems, assess their satisfaction with the process, and discover opportunities to optimize member health outcomes and manage costs. The platform supports coordination of care and transmission of health information to provider as children and youth in the child welfare system change placements, particularly if they move across counties or regions within West Virginia.

The business application system has processes to accurately and timely load updated PA requirements and review criteria. Aetna streamlined prior authorization processing by implementing automation, which reduces human data entry errors and expedites the turnaround times for PA processing and reviews. It is also compliant with HB2351 requirements. For example, while approximately 70% of PAs are still received by fax, we use Intelligent Character Recognition to assist intake staff in processing the fax images. The data gathered by this process, after a brief review, is entered electronically in an automated fashion. Once the PA is reviewed, it is either approved or denied. The following MIS sub-systems support our operations:

- **Provider portal** (Electronic Prior Authorization): Providers can access PA requests, add/inquire about precertification and referral status, amend or add precertification attachments and submit specialty pharmacy PA details
- **PA letters:** This system tracks key dates in the authorization process and sends Notice of Action letters via the member's and provider's preferred method of communication as well as posts the letters on the member/provider portals for review within the required timeframes.
- **Fax authorizations:** Automated tool used to receive, store and route incoming faxes
- **PA service requirement** (ProPAT): Automated tool assists providers determine whether a treatment procedure requires prior authorization

Please refer to **Figure E.1-5** for our UM data and process flow graphic. Our application allows departments to share member and provider information, as necessary and authorized by the member or their family, to coordinate processes such as discharge planning, transitioning a member from an institutional setting back into the community, authorizing post-hospital services, and following up on complex cases or ER care. Aetna's business application system also provides the authorization number and effective dates for authorization to participating providers and applicable nonparticipating providers. Aetna's business application system stores and reports the time and dates all service authorization requests received, decisions made regarding the service requests, clinical data to support the decision, review criteria, and timeframes for notification of providers and members of decisions.

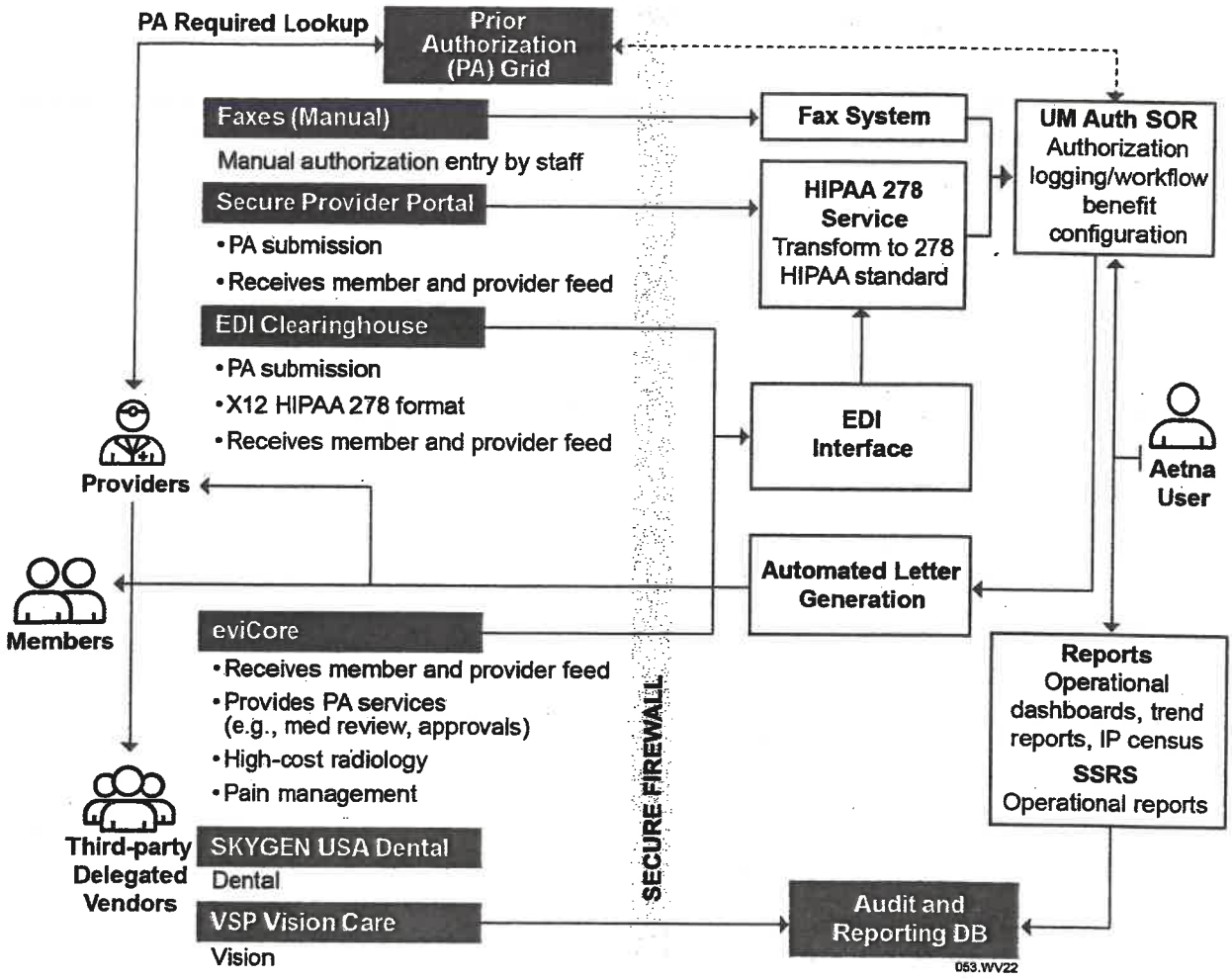


***Figure E.1-5: Utilization Management Data and Process Flow*** *- The utilization management system captures data related to authorization requests and subsequent authorization decisions*

## Systems to support timely claims payments [BA12]

Aetna's UM system works in concert with our comprehensive suite of IT systems to support care delivery, claims payment, and member and provider services in West Virginia.

### Utilization management system's ability to support claims payments

Our claims adjudication system is a HIPAA-compliant, rules-based information processing system. It includes 28 integrated modules that maintain and process health care administration data, allowing us to increase administrative efficiency and improve the quality of care. The system contains every data element required for claims data adjudication. Our claims hierarchical rules engine was built with a feature-flagging design that allows us to rapidly adjust the configuration to provide flexibility while minimizing down time and providing greater platform responsiveness. West Virginia claims import rules have been programmed and the application is built to ease turning rules and configuration characteristics on and off as needed without affecting the entire system, further ensuring service continuity. Additionally, claim adjudication edits are configured within the claims processing system to validate the accuracy and completeness of data allowing for the seamless submission of encounters. The system has over 400 business rules in addition to standard payment rules that are configured to

enforce policies and procedures. **As of September 30, 2022, our auto-adjudication rate for West Virginia Foster Care is 70.9%.**

### Medicaid management information system

Aetna's information system design uses powerful, reliable, and expandable data processing that support both physical health and behavioral health functions and claims. The foundation of this platform is a redundant, high-speed local area network and wide area network, with clusters of servers with built-in redundancy. This scalability allows systems to match any escalation in demand associated with DHHR's, network providers' and subcontractors' performance requirements, while at the same time maintaining system uptime and performance.

Over the last two years, Aetna's leadership conducted a comprehensive review of our information systems, which included stakeholder input from across our delivery continuum, to identify opportunities to improve the organization's capabilities and performance. We are using the results of this review to anticipate trends and demands in the Medicaid marketplace, and **the company is making a $50 million multi-year investment to upgrade and enhance our Aetna systems portfolio.** By leveraging the power of our national organization to better integrate data across our information systems, our upgrade and enhancement efforts focus on:

- Enriching member and provider digital experiences
- Integrating health information exchange and electronic medical record content
- Increasing data interoperability and simplifying secure data sharing
- Processing and paying claims efficiently
- Simplifying the service authorization and utilization management processes
- Leveraging automation and advanced analytics
- Enhancing coordination of care interactions

Aetna follows a secure and proven process for establishing and maintaining all EDI interfaces. We utilize industry-standard SFTP servers to handle inbound and outbound file exchanges. When establishing a new EDI interface, we collaborate with the State and trading partners to exchange key information required to establish the secure connection for exchanging files on both sides. These connections enable the implementation of a wide range of data sharing, including all HIPAA X12 file exchanges; examples include enrollment (834), claim payment/advice (835), health care claim and encounter (837I/P/D), prior authorization (278), and capitation premium financial reconciliation (820). In addition, Aetna supports the exchange of custom file interfaces whenever required by DHHR or other subcontractor systems.

Aetna also supports critical, real-time HIPAA transactions including eligibility inquiry and response (270/271) and claim inquiry and response (276/277). Additionally, Aetna continually promotes and adopts different transaction formats and protocols including HL7, the messaging standard that enables clinical applications to exchange data.

**Medicaid management information system** exchanges are handled by Aetna's national team, which works closely every day with our local West Virginia health plan staff to ensure timely, fully compliant processing of all inbound and outbound files. Aetna's IT team takes a business-focused strategy for MIS delivery. Our team is an independent, fully dedicated organization, which serves the Aetna quality, care, and delivery teams. Our vice president of IT program delivery, who has over 30 years of health care IT management experience, leads the Aetna IT team and is supported by a diverse team

comprised of over 400 individuals. The team is organized around specific business functions (digital innovations, member and enrollment, provider experience, claims and encounters, clinical management, and finance and reporting), which allow IT to be nimble and flexible to address the needs of the local Aetna plan.

Other dedicated teams are responsible for compliance, governance, infrastructure, global security, architecture, production support, and data and file management, which brings additional expertise to critical data-heavy functions like MMIS exchanges. These teams are fully versed in the latest data interoperability standard, including HL7 and the newer Fast Healthcare Interoperability Resources standards, and partners with the Aetna Quality team and Aetna which currently support both CMT/PreManage and WVHIN, electronic medical record data clearinghouses (i.e., Athena), and directly with large provider practices. The national team works in concert with a dedicated team of local West Virginia managers and support staff to ensure IT processes such as file transfers, enrollment, and claims processing, reporting, and all auxiliary systems are functioning properly and within State guidelines. Local staff works closely with the State's subject matter experts to assist in the delivery of solutions and turn the State's requirements into specific system or process designs for leading-edge solutions. The local team also coordinates the integration of all Aetna infrastructure support areas to ensure required IT resources are appropriately allocated to meet West Virginia's business objectives.

### Necessary interfaces

As described above, Aetna currently supports all Mountain Health Promise current data integration needs including eligibility, claims, reference files, case worker roster, SNS data, FSPs and ISPs from Kepro, and dozens of other MIS and Mountain Health Promise affiliated systems, all seamlessly managed through both web services and data file integration system. Our core books of records benefit from full interoperability of all datasets ensuring real time and near-real time synchronization. We share data with constituents through a myriad of methods:

- Market Leading Care Coordination systems FamilyConnect
- Payer agnostic provider administrative and report platforms, including provider VBS and practice roster dashboards
- Care Management systems customized to support the local market and program requirements of Mountain Health Promise
- Nationally recognized, industry leading COB/EOB and provider payment vendor platforms managed an providers' financials
- World class state analytics and reporting systems, currently supporting over 150 MHG customized reports fulfilling of the state contact

### Ability to support inbound member and provider inquiries

Our member portal allows the member or their guardian/parent to communicate directly with a plan representative through secure messaging. FamilyConnect allows the member or their guardian/parent to communicate directly with a plan representative through secure messaging and are also available via standard email and or telephone. FamilyConnect is compliant with the Americans with Disabilities Act of 1990 (ADA), NCQA guidelines and meets Web Content Accessibility Guidelines (WCAG 2.0 A), which ensures content accessibility by everyone, irrespective of disability or age.

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Aetna's secure FamilyConnect provides members, their foster and/or biological parents (as appropriate), the Agency caseworker, and other providers with tools, care plans, health record data, and other resources which support care coordination across the CCT.

FamilyConnect leverages responsive design that allows access through Android and iOS devices, tablets, and PCs to deliver access to care virtually anywhere.

**Secure provider portal.** Aetna's secure provider portal contains information on provider and member records, claim or authorization status, electronic explanations of benefits outlining claim services payment or denials, dates of service, procedure codes, amount billed and allowed, and amount paid, as well as the status of grievances and appeals. Providers can submit PAs and appeals and grievances through the provider portal. This web-based platform allows us to communicate member health care information directly with providers in real time, inclusive of member assessments and care plans.

In addition, we assist providers to optimize the use of their Electronic Health Record (her) and provide technical assistance to improve utilization of IT systems, including the Aetna provider portal, to improve provider satisfaction, health outcomes, and care integration.

This level of support will include advice on clearinghouse claims billing and support APM incentives. EHRs are available across internal departments and Aetna staff use them to understand better the member's medical condition and status of medication and DME orders. We also use EHRs for gathering data related to performance measures. We generate a daily inpatient and discharge report and share it with PCPs, PCMHs, and DHHR for care coordination purposes.

### Call centers

As described below, Aetna has significant experience running our local West Virginia call centers. which are staffed with knowledgeable personnel trained to fully support the needs of members and providers. Our personnel are specifically trained on the requirements, policies, and procedures of the West Virginia Specialized Managed Care for Children and Youth program (e.g., HIPAA-related concerns, SNS, and Aetna's system of care for serving youth in child welfare programs, etc.). They are specifically trained to support FamilyConnect and our UM platform and support inbound member and provider inquiries. Additionally, a FamilyConnect Administrator will be available to assist FamilyConnect users with access.

The calls through the call center are answered by live agents that can address claims, payment, IT, and access concerns. The call center staff also warm transfer claims and operations calls to operations team if further investigation is required. The member services representative follows up with the member to ensure resolution. All service lines are accessible via toll-free numbers, which are included on the member identification card, the member handbook, provider handbook, and the member and provider websites.

**Prior authorization line.** All staff working on the PA line are dedicated fully to Aetna. Providers have a direct-dial number and do not go through Interactive Voice Response (IVR) or a call tree. The PA line also has dedicated fax lines. **Between January and September 2022, the average speed to answer the prior authorization line was 0.3 seconds, and the percent of calls answered within 30 seconds was 99.58% with an abandonment rate of .07%.**

**Member services hotline.** Located in West Virginia, our dedicated health plan member services center is always staffed to maintain adequate capacity to support our member volume. Our members can contact member services support 24/7/365 to obtain convenient access to treatment or services,

referral assistance, and access to information about benefits or claims. **In 2021, a total of 1,872 calls were answered; for the first three quarters of 2022, a total of 2,499 calls were answered. Our current service level is at 91%, which exceeds the contractual requirement of 83%.**

We use workforce management software to forecast adequate customer service center staffing. Our member services call center runs on a top industry-standard internet protocol switch, which **maintains 20% extra capacity to cover any spikes and growth spurts.** We also cross train additional, supplementary, staff on West Virginia with the requirements, policies, and procedures necessary to provide overflow coverage during high volume times.

All member services staff, locally and nationally, can connect members to our 24/7/365 health information line or 24/7/365 behavioral health crisis services hotline for clinical support. In 2021, we answered 200 after-hour calls through our behavioral health crisis services hotline. Call center staff document relevant data in Aetna's utilization management system.

**Provider support service line.** Aetna is committed to continually improving our providers' experience and supporting their ability to render quality-driven services to our members. West Virginia providers have access to our toll-free West Virginia-based provider support service line to assist with enrollment, service authorization, contracting, or reimbursement questions or issues, and to resolve provider questions, comments, inquiries, and complaints. The provider service line is open for in-network and out-of-network provider questions Monday through Saturday, 7 a.m.-6 p.m. Eastern Time. For after-hours calls, callers receive an Agency-approved after-hours message with instructions for leaving a message and requesting a call back, which we will return during the following business day during normal hours of operation.

## Establishing and testing data exchange interfaces [BA13]

Aetna has an established history in West Virginia of creating and maintaining secure EDI interfaces with all key regulatory entities' systems (including MMIS) and other stakeholders, as necessary. Our MIS reporting standards use the American National Standards Institute's Accredited Standards Committee section X12 Benefit Enrollment and Maintenance (ANSI ASC X12N), and we comply with HIPAA-electronic transaction standards. We have also implemented required HIPAA transactions with every State agency with which they are contracted since HIPAA's inception in 1996. We follow a secure process for all file exchange interfaces and use a SFTP server to handle inbound/outbound file exchanges.

For instance, our enrollment manager application is used to support the exchange of HIPAA-compliant 834 enrollment files from DHHR in a manner that is consistent with the Agency's timeframes and frequencies. Once we receive an 834-enrollment file, we compare the file's member record details to the existing data within our electronic claims management system. Each member record is fed through our highly configurable rules-driven member enrollment processor, which identifies matches, consolidates, and transforms the member information to ensure proper updates to our member demographic and age-specific data, enrollment benefit plan assignments, PCP assignments, member classifications, authorization, claims payment data and other clinical information.

Another example is our **encounter management system**. We use this system for encounter submission, which includes validation of medical and subcontracted vendor encounter data for compliance purposes using standard HIPAA guidelines and SNIP level four edits. This system provides comprehensive validation steps that ensure our files are accurate and complete before submission to the state. Our MIS works seamlessly and supports a secure interface and data exchanges with DHHR

and other entities through SFTP with other systems through the State's file transfer protocol (FTP)/SFTP service. We follow a secure process for all file exchange interfaces and use a SFTP server to handle inbound/outbound file exchanges. We verify successful inbound/outbound file transmission, employ a rigorous combination of automated/manual processes to validate successful exchange of files and notify DHHR as applicable. File monitoring software alerts automatically in the event of a failure and if a failure occurs, production support is immediately engaged to research and resolve the issue. An audit trail for all inbound and outbound files and data processed is generated and retained in a separate database that is retrievable for audit and compliance purposes.

### Interface with State Agencies and other External Partners

Aetna seamlessly interfaces with State agencies and all external partners including stakeholders, vendors, and subcontractors. Our robust file management process ensures all department files are fully implemented and verified in our systems as well as with our subcontractors and network providers. To validate compliance with HIPAA and seamless connectivity/minimal interruption of services provided by all vendors/subcontractors, Aetna is currently in compliance with the recently released Statement on Standards for Attestation Engagements No. 18 (SSAE 18), which has enhanced requirements for adequate control environments for vendors/subcontractors.

**In all data exchanges, we strictly adhere to federal and state law for securing and protecting the confidentiality of medical records. These laws include but are not limited to 42 CFR Part 2, 45 CFR Parts 160 and 164, as well as our internal policies and procedures.** Working with the Health Information Exchange (HIE) to incorporate data points and supplemental information protocols supports identifying challenges, mitigating risks, and being flexible in coordinating care with DHHR and behavioral health and physical health providers. We leverage both provider-facing and internal coordination to improve member health outcomes. We also comply with data governance guidelines and the Health Information Technology for Economic and Clinical Health (HITECH) Act requirements.

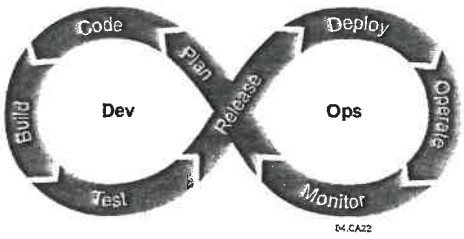
**Agency-specified interfaces.** We will continue to support all existing and future state Agency-specified interfaces, including MMIS, Failure and Accidents Technical Information Systems (FACTS), Program for Appropriate Technology in Health (PATH), and additional systems added to Medical Evaluation Specialists (MES). In addition, we collaborate with Kepro to consistently meet all State interface requirements. Examples of current data exchanges with agency-specified interfaces include:

- Ingestion of supplemental enrollment information for foster care members
- Sharing Aetna eligibility information with Kepro
- Receive SNS Service authorization requests from Kepro and adjudicate
- Ingest Service Plans from Kepro (e.g., FSP and ISP)

We will leverage the best practices in file management (including SFTP), EDI interfaces, change management framework, testing methodology and tools to comply with and support upcoming Agency specific interfaces.

### Testing systems

Aetna's testing methodology and MIS provides an objective, independent view of our software implementation to allow the business to validate that our systems are functioning as mandated by contract requirements, including current West Virginia state systems such as MMIS, and integrated eligibility



solution. We applied this same testing methodology when building the data integration interfaces with the Agency, such as FACTS and PATH, as these were designed and implemented under the original contract. We use our change management framework to leverage automated code deployment and testing tools for continuous integration and delivery processes, which balances quality and speed to meet the State's objectives. We emphasize the collaboration and communication between software developers, configuration management and testing teams, while automating the process of software delivery and infrastructure changes. This approach is supported by a culture and work environment where building, testing and releasing accurate software happens rapidly, frequently and smoothly. Our change management framework includes the following processes:

- **Continuous integration**: Merge state-specific code into a common source code repository and execute consistent build, quality check, and unit testing processes
- **Continuous delivery**: Rapidly deploy the development version of the software into higher environments, including production
- **Continuous testing**: Apply automated code testing at every stage of project lifecycle and provide detailed feedback on quality; repetitive, automated testing reduces error rate and shifts manual efforts to focus on end-user validation
- **Continuous monitoring**: Utilize structured processes and tools to intelligently monitor, analyze and manage applications and MIS infrastructure in the production environment

Our Aetna is configured in a dedicated test environment that supports a wide variety of types of testing used during the project lifecycle. Each type of testing, which will be a part of our approach for the Specialized Managed Care for Children and Youth program, is accompanied by robust testing artifacts, including, but not limited to, strategies, scripts/test cases, and test results summary that can be traced back to the following State requirements:

- **Unit testing**: tests functionality and is executed by developer who builds the code.
- **System testing** (positive and negative): assesses the proper behavior and functionality of an application based on business requirements and application design.
- **Performance testing**: Adding load to the components to ensure the system meets the non-functional requirements. For example, we test a large volume of claims to ensure claims are processed appropriately and the system is able to handle the load.
- **Regression testing**: examines the application determine if it is operating in a business-as-usual mode and that it has not been affected negatively by changes; automated test scripts are executed where possible to validate that there are no additional impacts on upstream and downstream applications.
- **End-to-end testing**: performed to see if data flows from one application to the other and works as expected (e.g., claims end-to-end testing includes file load/import, adjudication, payment check run, and encounter process).
- **User acceptance testing**: validates the business requirements using defined user acceptance test strategies, plans, script/test cases and verifies that the application/file(s) functions as expected, and no defects are encountered.
- **State testing**: we exchange data file(s) with the State to validate that MMIS, MES and related system changes and logic are compatible with requirements and are certified by the State. Our

dedicated team facilitates testing between the State, vendors, and Aetna utilizing any State-specific testing tools required.

- **Production checkout testing**: Confirms that all application changes have been migrated successfully to the production environment and all functionality is working properly.

Our testing team leverages the latest industry standard tools and best practices. We can deliver changes within days which are fully built and tested, all with minimal manual intervention. The process provides visibility to status, defects, feature progress, and other software delivery metrics, while automatically moving software code through the delivery platform. Our software testing provides an objective, independent view of the software to allow the business to understand the risks of its implementation. Aetna's testing platform is designed to discover impacts to new code or new configurations in minutes of delivery to the testing environment.

## 2. Care Management

**The Vendor should refer to the relevant specifications located in Appendix 1: Detailed Specifications (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in Section 4: Project Specifications in this RFP, and then describe its approach to Care Management below. The Vendor's narrative response should not exceed 60 pages.**

Aetna Better Health of West Virginia (Aetna) offers excellence in our care management infrastructure, through **localized, culturally responsive care management, delivered by West Virginians** in our regional **Care Connection teams.** Our care coordination staff **understand West Virginia values, the needs of both rural and urban members, and regional engagement and service access differences.** Care Connection teams actively empower members, families, guardians, providers, caseworkers, and stakeholders to collaboratively engage in care planning grounded in member and family perspectives, such as those depicted in Figure E.2-1. We focus on providing the member with options that fit their holistic needs, values, cultural views, and preferences, integrating physical, behavioral, and social care. Our care management program incorporates proven clinical models in a customized manner to meet the State's goals related to coordinating access to services, defragmentation, keeping members connected to their families, and offering needed supports and services to maintain the safety of the members we serve. Our care coordination activities have led to a **12% increase in PCP visits/1,000 from 2020 to 2021**. Comparing year-to-date utilization through June 2021 versus June 2022, we have seen an **82% reduction in substance use disorder (SUD) inpatient admissions, 24% reduction in mental health inpatient admissions, and 19% reduction in physical health inpatient admissions.**

Approximately 46% of Mountain Health Promise members are in the adoption program, 44% in foster care, 7% in legal guardianship, and 3% in children with serious emotional disorders (CSED). As the Mountain Health Promise MCO, we have managed the special health care needs of members and their families/caregivers and have developed collaborative relationships with stakeholders and with state caseworkers whom we recognize are under incredible strain. **We have advanced person and family self-sufficiency, recovery, and resiliency, and kinship care** using child and family-centered wraparound approaches that focus on **high touch, face to face interactions.** We have reduced placements overall, implemented effective and member/family-centric solutions in challenging placement scenarios, and prioritized keeping members with next of kin and in their communities of origin. We employ tailored care coordination approaches to address issues members experience such as high-risk pregnancy, Neonatal Abstinence Syndrome (NAS), and/or opioid dependency.

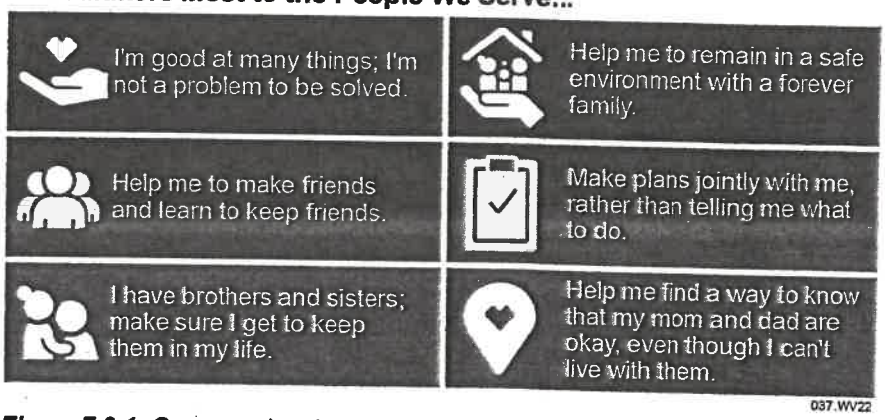
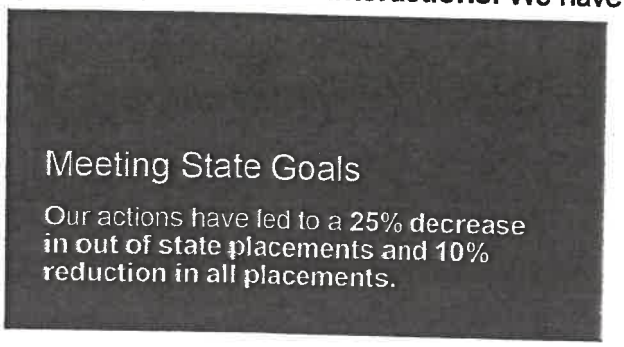



***Figure E.2-1:** Our care planning process meets members' specific needs.*



To meet the specific needs of children and young adults in West Virginia's child welfare system, we implemented **innovations** such as the inclusion of **embedded staff** at key providers/facilities and the Bureau for Social Services (BSS) offices and **expanded our CSED care coordination team 150%** since go-live to meet the growing membership's specialized service needs. Our additional CSED staff capacity helps us keep youth in their homes and communities, coordinating wrap services to prevent residential placements. Additionally, our **HEERO workshops (Helping Each Other/Everyone Reach Out)** offer members education about the effects of trauma on health and tools that members and families can use to create supportive networks. In June 2022, we launched our **Working for Success** program with Job Corps in nine counties (with plans for expansion) to help young people ages 16–24 complete their high school education, train for meaningful careers, and obtain employment.

West Virginians are affected by social determinants of health (SDoH), including economic hardship, unemployment, and food insecurity that can affect access to health care, achieving optimal health outcomes, and meeting personal goals for health and wellness. We use data and leverage our relationship with **Socially Determined** to mitigate SDoH and health disparity impacts to members, linking members to social services such as food banks, benefit assistance, and housing supports. According to America's Health Rankings, West Virginia is ranked 46th with respect to Adverse Childhood Experiences (ACEs) and according to the Child and Adolescent Health Measurement Initiative, 49% of West Virginia youth have had at least one ACE. To address the significant impact of ACEs on members in the Mountain Health Promise program, we have established trauma-informed care (TIC) training for staff and providers and helped create the WV ACES Coalition eight years ago to improve staff and provider application of TIC principles. This Coalition is now part of the PACES Connection Cooperative of Communities.

Throughout our response, we identify response language with the relevant detailed specifications requirements number. Specifications numbers associated with more than one part of the care management journey may be addressed in multiple header/topic areas throughout the response.

## Local care management infrastructure and functions [CM01, CM09, CM14, CM20, CM21, CM23]

| | |
|---|---|
| CM01 | The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated Vendor care plan for all children. Additionally, the Vendor should identify individuals with complex or serious medical conditions, including, but not limited to, children with a serious emotional disorder (CSED), on an ongoing basis and track members with high physical and/or behavioral health needs to assure continuity of care.<br>The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.<br>Information on the WV CSEDW can be found at the following link:<br>dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx |
| CM09 | The Vendor should assign an initial risk stratification tier within the first 30 days of enrollment. For those enrollees who require Intensive Care Management (ICM) the Vendor should determine the composition of the ICM team and develop a care plan specific to each case for members with one or more chronic conditions.<br>The Vendor should also review all treatment plans for members placed in a Residential Mental Health Treatment Facility (RMHTF) or Psychiatric Residential Treatment Facility (PRTF) at a minimum of monthly to ensure appropriate treatment and participate in meetings with the RMHTF or PRTF as requested by the Agency. The Vendor should also complete a 90 day review of the treatment plan to assess appropriateness of a discharge to a less restrictive setting.<br>The Vendor should describe how it will identify children/youth who exceed Level 3 needs and any children/youth who require a more intensive care management strategy to address complex cases, high priorities, children dually involved in the child welfare and juvenile justice systems, and/or if BSS determines the need. |

| | |
|---|---|
| CM14 | The Vendor should provide a care coordination model with stratified services for members according to clinical, social, or other Vendor-proposed criteria as approved by the Agency. The Vendor should facilitate coordination of care between primary care providers (PCPs) and any other providers that the child is working with to include, but not be limited to, the children's behavioral health, specialty, vision, and dental providers for populations eligible for medical services, This includes, but is not limited to, children with special healthcare needs.<br>See Appendix 3: Service Provider Agreement, 6.3.2 Coordination of Care for more information on coordination of care and risk stratification expectations.<br>1) The Vendor should provide a detailed description of its care coordination model.<br>2) The Vendor should describe how the care coordination department is organized and the integration of the service types.<br>3) The Vendor should describe its proposed clinical, social, or other criteria to be used for member stratification.<br>4) If applicable, the Vendor should include an explanation of how the Vendor will work with other parties to administer this care coordination, including, but not limited to, subcontractor(s) and affiliate advocacy group(s).<br>Note: The Agency expects all members to be eligible for care coordination services |
| CM20 | The Vendor should develop and maintain qualifications and training for Vendor staff who will be involved in coordinating care.<br>The Vendor should describe:<br>1) Qualifications and training for Vendor staff who will be involved in coordinating care<br>2) The Vendor's plan for hiring care coordination staff, including, but not limited to, time frames, number of care coordinators, and maximum case load<br>Note: Care coordinators should be dually trained in both Bureau for Children and Families (BCF) and Bureau for Medical Services (BMS) policies. |
| CM21 | The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members. See Appendix 3: Service Provider Agreement for additional information on the role of care coordinators.<br>The Vendor should describe in detail:<br>1) Steps care coordinators will take to establish relationships with their assigned members.<br>2) A protocol for addressing a member who does not want a care coordinator or cannot be reached once a care coordinator has been assigned. |
| CM23 | The Vendor should monitor and evaluate care coordinators at a set frequency regarding establishing relationships with members, including, but not limited to, collecting statistics on completion of Vendor care plans, and data on care coordinators' progress toward establishing relationships with members.<br>The Vendor should describe what statistics it proposes to collect and how often. |

We offer Care Connection teams which:

- Offer a regional and embedded infrastructure of qualified, well-trained care coordination staff
- Are supported by peer specialists, community health workers, and our Care Advocate Team, and
- Manage member care according to care coordinator to member ratios that we have tailored to promote quality, high touch service to individuals according to their specific needs

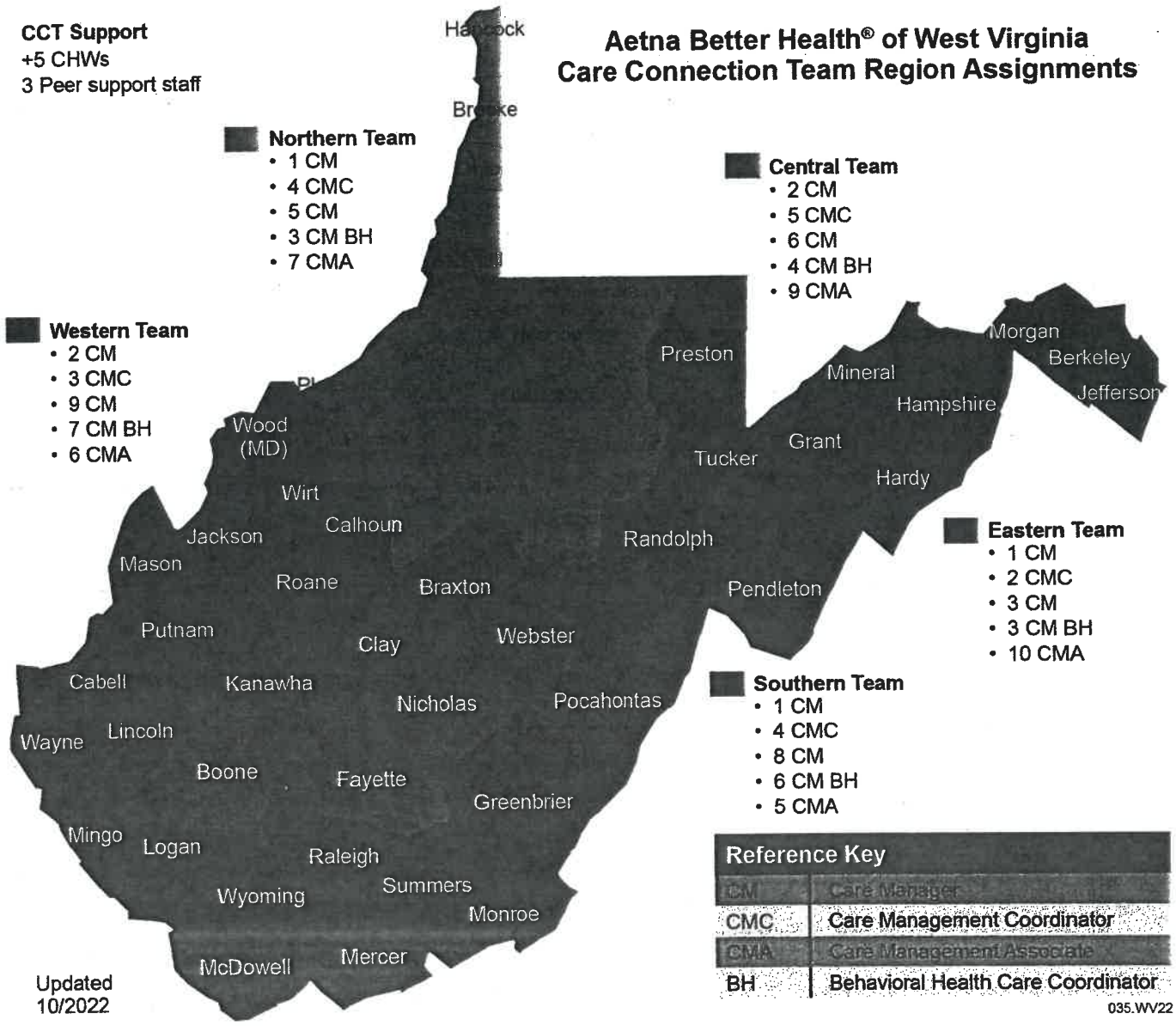



***Figure E.2-2: Regional Care Connection teams.*** *We have well-established local Care Connection Teams which include experts in regional health care needs and available services.*

## Care Connection team infrastructure and role [CM01, CM14]

Figure E.2-2 depicts our regional Care Connection team's configuration for Mountain Health Promise members.

[CM14] Our regional Care Connection teams are organized to include staff who live in the communities in which they work. In fact, **93% of our integrated Care Connection team members live and work in West Virginia,** which allows us to meet the individual needs of members in rural and urban areas through face-to-face contact. **The Care Connection teams act as the hub for coordination and continuity of care for members.** We partner with their guardians/families and chosen circle of support, physical, behavioral health, other specialty and ancillary providers, vision, dental, and SNS providers, child welfare providers, and all members of the larger interdisciplinary care team (ICT) [CM01, CM14].

**Care Connection teams care coordination staff**, which include care management associates, care management coordinators, and clinical care managers (care management-nurse and care management-licensed behavioral health clinicians) **are the backbone of our care coordination model**. Each Care Connection team includes an SUD specialist (nurses or licensed behavioral health clinicians) who offer expertise on regional resources and referral processes as they relate to SUD services. Our Medical Directors and pharmacy director are directly involved with the Care Connection teams to consult on member specific issues. They can connect with treating providers for consultation and case review to support the provider and the services provided. Our SUD peer support specialist is available to support the team in connecting members with SUD to needed services. We also plan to offer a **parenting peer support specialist** as well as a **foster/adopted peer support liaison** to support the Care Connection teams in helping biological and foster/adoptive families, respectively, navigate and connect to services. Five **community health workers** also support the regional Care Connection teams, offering health and resource navigation support to members. Care Connection team staff also work closely with our Care Advocate teams, described in greater detail later, to address members' needs.

Given our longstanding presence in health care delivery in West Virginia and our role as the Mountain Health Promise MCO, **our regional Care Connection teams have nurtured positive and collaborative partnerships over many years with state stakeholders, local providers, child welfare experts, and other community-based organizations**. We have proven productive working relationships with the Department, BSS, the Division of Corrections, the Bureau of Juvenile Services (BJS), the Bureau for Medical Services (BMS), and the Bureau of Behavioral Health (BBH). Care Connection teams care coordinators take part in the department's multi-disciplinary team (MDT) and case planning process and incorporate the recommendations of the Department's individualized service plan (ISP) into the member's care plan. We have completed **346 Department of Health and Human Resources (DHHR) onsite visits** during which we assist in making referrals, review care plans, provide resources, and attend court appointments. We are also offering to train and help link stakeholder staff with our FamilyConnect care coordination application and provided training to stakeholders on the Child and Adolescent Functional Assessment Scale (CAFAS), discharge/level of care planning, and ACEs. We also provide a project manager to coordinate urgent issues at the BSS Commissioner's office.

**Additionally, we have embedded our care management staff at BSS offices in almost all counties as well as in provider and facility locations, as described in the table below.**

| Region | Provider Location |
|---|---|
| **Northern** | • Chestnut Ridge (Behavioral Health)<br>• Weirton Hospital<br>• Wheeling Hospital (neonatal abstinence syndrome [NAS] program only)<br>• WVU Ruby Memorial |
| **Central** | • CAMC (UM and care management): Women and Children's Hospital, General Hospital, Memorial Hospital, and OB GYN Center<br>• Dr. Ammar Shammaa-Women Care Clinic<br>• Highland Hospital-Behavioral Health<br>• St. Francis Hospital (UM, care management) Thomas Memorial Hospital |
| **Western** | • Edwards Comprehensive Cancer Center<br>• Lily's Place<br>• Marshall Health |
| **Southern** | • Dr. Ammar Shammaa-Women Care Clinic |

| Region | Provider Location |
|---|---|
| | • Beckley Appalachian Regional Hospital (Behavioral Health)<br>• Pavilion (Behavioral Health)<br>• Williamson Health & Wellness Center FQHC |

These co-located relationships foster seamless access to service, increased communication, and improved coordination of care due to the proximity of Care Connection team staff to the direct service providers and caseworkers. We are currently working with BSS and all active **Drug Free Moms and Babies Project** sites. This program provides early intervention to mothers and babies affected by SUD. We collaborate with the Perinatal Partnership, BSS, community stakeholders, and providers to complete a Plan of Care Form prior to a baby's delivery. The Plan of Care Form addresses the comprehensive needs of the family. The ICT completes the form and make referrals to community providers as necessary. They pay special attention to the infant and mother's medical needs, as well as the mother's substance use and mental health needs. This program helps prevent children from entering the child welfare system by connecting mothers to necessary treatment programs and developing a Safe Care plan.

## Care coordinator staff hiring, ratios, qualifications, and roles [CM20]

[CM20] We hire care coordination staff with comprehensive knowledge of the needs and challenges of the Mountain Health Promise population. They have **extensive experience and training in conducting assessments, facilitating integrated care planning, using clinical models, navigating the child welfare system, and conducting ongoing care coordination.** Our Care Connection team staff possess professional experience in specialties such as NAS, school-based therapy and nursing, Early Intervention and Head Start, Right from the Start, Juvenile Drug Courts, SNS, and Safe at Home, to name a few.

**Our current Care Connection teams include 116 staff** who coordinate care for members in the Mountain Health Promise program: 31 nurse CMs, 23 behavioral health CMs, 18 care manager coordinators, 37 care manager associates, and 7 care management managers. As the needs of the membership changes, we adjust our staffing model or provide additional training to our team to better meet those needs. For example, we increased our CSED team staff as CSED membership has grown and added additional Care Connection team resources in the eastern panhandle of the state where the BSS workforce is more limited in number. We also continually hire new staff as needed to meet our caseload ratio expectations.

Because we have served members in the Mountain Health Promise program and we recognize that their complex clinical needs and acuity can change, we have made the decision to adjust our staffing ratios to those listed below.

- **Tier 1** Population Health Care Coordination: 1:350
- **Tier 2** Supportive Care Management: 1:36
- **Tier 3** Intensive Care Management: 1:17

These ratios enable our Care Connection team staff to adjust their level of interactions and support based on the needs of members. Appropriate staffing ratios are essential to a balanced and successful care management program. We have **tailored our staffing ratio tool for caseload development to the meet the needs of Mountain Health Promise membership** based on quality of care reviews and workload studies that consider time elements, such as how long it takes to schedule and complete an assessment, call a member, or drive to a member's home, as well as time for case rounds with the

medical director, community-based service collaboration, ICT meetings, personal development enrichment, training, supervision, and documentation. Care management managers review caseload ratios and case weights (which factor in the mix/numbers of Tier 2 and Tier 3 members assigned to an individual care coordinator) monthly and any time there is a significant addition of new membership. When a care coordinator's caseload approaches maximum thresholds (based on maximum ratios and case weights), our leadership team conducts a staffing review. Based on the results of this review, we submit a requisition to hire additional care coordinators or reallocate resources, without exceeding the maximum target ratios, in a manner that enables us to provide members the services they need in an agile manner.

Care coordinators may be care management associates, care management coordinators, or nurse or licensed behavioral health clinical care managers. Staff qualifications and role descriptions for the different types of care coordinators are as follows [CM20]:

- **Care management associate:** Coordinates medical services through activities including intake, screening, and implementation of care plans to promote effective utilization of health care services; may be assigned as care coordinator for members in the Tier 1 population health care coordination; promotes/supports quality effectiveness of health care services; must have high school diploma or GED
- **Care management coordinator:** Utilizes critical thinking to inform the care management process and support health care outcomes for members by providing coordination, support, and education; typically assigned as the care coordinator for members in Tier 2 supportive care management; bachelor's degree or non-licensed master level clinician is required, with either degree being in behavioral health or human services preferred (psychology, social work, marriage and family therapy, counseling)
- **Care manager-nurse:** Responsible for assessment, planning, implementing, and coordinating all care management activities with members to evaluate medical needs and facilitate the member's overall wellness; facilitates development of a care plan to enhance the short- and long-term outcomes and members' overall wellness through care integration; assigned as the care coordinator for members in Tier 3 intensive care management whose primary needs relate to multiple or complex chronic conditions; may act in role of crisis intervention specialist to respond within 24 or 72 hours to children who have been placed in foster care if they have 3 or more years of behavioral health experience and have had specific crisis intervention training; care management nurse must be a registered nurse with current unrestricted state licensure
- **Care manager-licensed behavioral health clinician:** Utilizes advanced clinical judgment and critical thinking skills to facilitate appropriate member physical health and behavioral health care through assessment and care planning, direct provider coordination/collaboration of psychosocial wraparound services; assigned as the care coordinator for members in Tier 3 intensive care management whose primary needs relate to behavioral health conditions; may act in role of crisis intervention specialist to respond within 24 or 72 hours to children who have been placed in foster care if they have 3 or more years of behavioral health experience and have had specific crisis intervention training; must be a licensed behavioral health clinician with minimum of a master's degree in behavioral/mental health or related field

Qualifications and roles of staff who support the Care Connection teams include:

- **Peer support specialist:** Shares lessons learned through personally lived experience to help members become and stay engaged in the recovery process and reduce the likelihood of relapse;

participation on the ICT as requested; three years' experience in community/outpatient setting working with members in a mental health or substance use setting is required; training in/experience with Mental Health First Aid, Trauma Informed Care, HIPAA, C.L.A.S. Standards preferred; if not certified, completion of a Certified Peer Support Training Program is required within one year from start date; Peer Support Specialist certification is preferred; High School Diploma or G.E.D. required

- **Community Health Workers:** Serves as a liaison between the member (community) and health/social services to improve members' navigation and access to services, benefit eligibility applications, Charting the LifeCourse care planning and goals, and accessing non-medical services; participates on the ICT as requested; educates health care professionals about SDoH and cultural impacts to members' health; 1-2 years' experience providing clinical services; experience in community/outpatient setting preferred; Community Health Worker Certification or equivalent training and experience preferred; Bilingual/target population required; experience in serving the Medicaid Populations in urban or rural environments with familiarity of local formal and informal resource networks preferred

We value the members of our Care Connection teams and acknowledge the secondary trauma they may experience because of the daily work with our most vulnerable members and families. **To support their mental health and to foster staff retention, we implemented a new program that offers staff tips and education to address compassion fatigue and vicarious trauma.**

## Care coordination staff training [CM09, CM20, CM21, CM23]

Upon hire, we train staff in various content areas both through live training sessions and through online Relias Learning Management System modules [CM20]. Training topics include not only processes, but clinical models and approaches such as Wraparound, trauma informed care, and ethics as well. Numerous training modules focus on the importance of building compassionate, person and family-centered relationships with members and the steps care coordinators can take to develop these relationships [CM21]. Care management managers track new employees' completion of initial training through our training and orientation checklists. We provide our **Integrated Care Management Basics for Care Managers manual** to new employees and review these during the initial training phase. This manual covers topics such as those in the table below [CM20, CM21]:

| Care Connection Team Staff Training Topics | |
|---|---|
| • The role of the care coordinator and development and maintenance of relationships with members<br>• The role of the ICT including the following:<br>– Who participates on the ICT<br>– Supporting providers in medical homes, assisting in assuring integration of services and coordination of care, and helping provide care management for members<br>– Assuring appropriate and efficient care transitions including discharge planning<br>– Assessing the physical, social, and behavioral risks and needs of each member<br>– Providing medication review<br>– Providing member health education on complex clinical conditions and wellness programs<br>– Assuring integration of primary, specialty, behavioral health, and referrals to community-based resources | • Trauma-informed care, Compassion Fatigue, and Vicarious Trauma<br>• Motivational interviewing<br>• Mental Health First Aid<br>• Human Trafficking<br>• Family First Prevention Services Act and other federal and State policy<br>• Conducting face-to-face visits<br>• Cultural competency, cultural intelligence, implicit bias, and health equity<br>• Gaps in care<br>• Use of available member education materials<br>• Assessment and treatment of SUDs and American Society of Addiction Medicine criteria<br>• Behavioral Health services<br>• LGBTQ+ (lesbian, gay, bisexual, transgender, and questioning or queer) community<br>• Addressing obesity in individuals with mental illness |

**Care Connection Team Staff Training Topics**

- Maintaining frequent contact with members including face-to-face visits, email, and telephone options
- Assisting in developing, updating, and monitoring a person-centered care plan
- Clinical guidelines for chronic conditions and other special health care needs
- Review of the Recovery Model, which focuses on the possibility of recovery, that the path of recovery is individualized, and that there is hope through recovery.
- Case scenarios
- Documentation standards
- Care management policies and standard operating procedures
- Lactation
- National Diabetes Prevention Program
- Individuals' rights
- Introduction to Milliman Care Guidelines
- Improving health care quality and identification of quality-of-care issues
- Medical necessity
- Confidentiality
- Service excellence
- Medicaid 101
- Review of BSS and BMS policies
- Local review of State and county health improvement plans, United States Department of Agriculture local Women, Infants, and Children (WIC)/Supplemental Nutrition Assistance Program (SNAP) numbers-data and education on demographics and socioenvironmental factors

We also provide staff extensive information systems training as it relates to the documentation of, storage, and sharing of screenings, assessments, and care plans with members of the ICT including the member/family/guardian, PCP, specialists, and others given permission for access by the member/family/guardian. This training includes review of our locations which may store and share member assessments and care plans such as: our electronic care coordination system, FamilyConnect, provider and member portals.

We provide **ongoing monthly training** to care coordination staff through our Relias (online training), Aetna Learning and Performance, local support trainers, and Continuing Education Direct on a variety of topics and required compliance trainings. We encourage care coordinators to attend a health care summit or conference (pertinent to their background, role, and the services they provide) once per year and we require licensed staff to complete continuing education units as necessary to maintain licensure.

[CM09, CM23] **To identify opportunities for needed additional or enhanced training, care coordination leadership conduct audits (monthly)** and periodic review of tenure reports to ensure that care coordinators complete screenings, assessments, care coordination, tier/risk identification, and care/treatment plans within all initial and ongoing/update required timeframes. **Care coordinators also self-monitor** timely completion of these elements daily through a search function in our electronic care coordination system that allows them to see when update tasks (such as an annual reassessment or required care plan update) are coming due or if any are overdue. [CM21] Additionally, leadership monitors the ability and success of care coordinators' establishment of relationships with their assigned members through an **observational audit tool** twice per year that evaluates the care coordinators use of motivational interviewing techniques and wraparound process efficacy. Our current observational audits show **adherence to motivational interviewing techniques in 95% of interactions**. All these auditing and monitoring processes identify whether the care coordinator is building positive relationships with their members that result in meaningful interventions and outcomes. Leadership also **checks care management opt-in versus opt-out percentages on a monthly basis**. If a particular care coordinator's opt-out rates are rising, it may be an indicator of an opportunity to improve relationship building skills, such as Motivational Interviewing skills. Finally, we assess a care coordinator's success in establishing strong relationships with members and their guardians through member satisfaction surveys, which members/guardians complete if or when they disenroll from care management services [CM21, CM23]. If we find deficiencies in any audited and monitored areas

described above, we may enhance training curriculum for all staff, provide more supervisory oversight to the relevant staff, and/or may refer a case for MDT review.

## Care advocate team

We created our **Care Advocate Team (CAT)** of specialty administrators, formerly known as System of Care (SOC) administrators, to address the specific needs of West Virginians. The CAT participates in development of a comprehensive network of statewide, community, and plan-based services that reduces barriers, improves access, and identifies and solves for systemic process challenges to meet the needs of members and their circle support. **They are leaders in system transformation who partner with local, federal, and national resources.** West Virginia's State goals to increase access to services, improve communication and training among stakeholders, and reduce system fragmentation guide the CAT administrators' actions to impact service delivery and to promote, restore, and maintain the health of members. Our CAT model achieves the following:

- Drives collaboration across agencies and community-based organizations to solve barriers and challenges
- Builds meaningful partnerships and takes part in solution identification with providers, state and local agencies, and stakeholders
- Identifies gaps and potential systemic solutions that address target populations (e.g., CSED, out-of-state children)
- Serves in a cross-functional capacity collaborating with multiple departments, acting as a conduit for both internal and external communication

### CAT Administrator and CCT help a member return to the community

Prior to Aetna's role as the MCO for Mountain Health Promise, Jimmy had been removed from his parents due to physical abuse, neglect, and SUD. Soon after his adoption, he was admitted to an out-of-state PRTF and by the time he was enrolled with our plan, he had been in this placement for almost a year. He spent a lengthy period of time in the facility despite achieving his treatment plan goals at the facility very quickly because his adoptive parents wanted him to remain at the PRTF. Eventually, they relinquished rights to him. To raise awareness of Jimmy's situation once he was placed in the state's custody, and to enlist assistance in finding him alternative care, our CAT Child Administrator presented his case at the Foster Care Provider-specific meeting and the PRTF level 1 and 2 Provider-specific meetings. Our CAT Child Administrator and Jimmy's Aetna CM worked closely with BSS to find a new, safe family for Jimmy and to help him apply for CSED waiver services, which is still pending. In the meantime, we have engaged Jimmy and his family in Safe at Home services to ensure continued success in the home. The family state that Jimmy is fitting in well "like he has always lived here" and they want to be his forever home.

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Our CAT collaborates with key Mountain Health Promise stakeholders, community, and state partners to resolve barriers for regional Care Connection teams . For example, if the Care Connection teams identify a trend with gaps in services or barriers to continuity of care, the CAT administrators may help with finding solutions to meet the need or mitigate the barrier. Additionally, the care coordinator can engage the CAT administrators who meet with the State waiver office representatives to find the fastest way to share information to get services to children and families in a streamlined manner. Through strong internal communication avenues, CAT administrators ensure Care Connection team staff are aware of and know how to connect to community resources and provider networks for West Virginia's population. The table below describes our CAT members and their roles:

| CAT Title | Functions/Role |
|---|---|
| **Child Administrator** | Collaborates with the following internal and external partners:<br>• West Virginia SNS liaison to build community relationships, services, and supports specific to the WV foster care population<br>• Regional providers to address gaps and concerns in rural areas for foster care and youth |

| CAT Title | Functions/Role |
|---|---|
| | • Aetna network team to develop a comprehensive service array including trauma treatment providers, services that allow members to remain with their families and avoid home removal, and adoption competent therapists<br>• Help and Hope West Virginia, West Virginia ACEs c=Coalition, Drug Courts Family Seeing, Child Placing Agencies, BSS, with focus on enhancing support to children and youth<br>• Child Advocacy Centers, Court Appointed Special Advocates, and West Virginia Child Advocacy Network to promote community integration and coordinated systems for members and families |
| **Adult Administrator** | Collaborates with adult welfare, adult corrections, and other adult-serving agencies, and is responsible for:<br>• Conducting market surveys to identify system gaps; collaborating with health plan staff including value-based solutions, providers, and stakeholders to mitigate gaps<br>• Developing and implementing community support programs and processes such as the WV Home Visitation Program, to ensure we meet the needs of adults and families<br>• Identifying solutions for members aging out of foster care population and developing initiatives to strengthen families<br>• Enhancing quality approaches along the continuum of care<br>• Addressing gaps and identifying solutions in collaboration with the Medical Management team related to crisis service delivery including solutions to ED holds, SUDs (opioid epidemic), reduction in out-of-state placements, and developing innovative solutions to serve difficult to place members<br>• Coordination with internal departments to drive service development for special populations including adults with history of foster placements and members with childhood trauma |
| **Recovery and Resiliency Administrator** | Builds supportive programs, interventions, and education related to resiliency, member advocacy, person centered care, foster family and biological family support, and recovery maintenance that focus on the role of members, youth, and families in driving their plan of care; responsibilities include:<br>• Chairing the focus group that reports to the Member Advisory Committee<br>• Collaborating with the network development director to coordinate peer-to-peer networks such as the National Alliance for Mental Illness, West Virginia, and other non-traditional providers to serve children and youth<br>• Advocacy for service environments that are supportive, welcoming, and recovery-oriented by working with providers to implement TIC service delivery approaches and other initiatives<br>• Collaborating with other CAT administrators to advocate to further develop and implement member voice and choice principles with target member population<br>• Identification and implementation of innovative solutions that promote community tenure and reduce out of home placements to mitigate gaps. |
| **Juvenile Justice Administrator** | Serves as the single point of contact to communicate with the court and justice systems and acute care contractors, including interaction with mental health courts, drug courts, family courts, and other jail diversion programs and is responsible for:<br>• Connecting multiple systems of care including the West Virginia judicial system and the BSS<br>• Interacting with residential hospitals, psychiatric hospitals, the criminal justice system, community providers, and others who interact with offenders<br>• Coordinating efforts with the CAT team (as well as West Virginia key personnel and staff) to develop services and supports that focus on SDoH<br>• Developing and building programs and services related to the prevention, treatment, and reduction of SUD in coordination with other judicial agencies<br>• Addressing the WV opioid epidemic with the development of preventive services intended to reduce the rate of youth entering out of home care<br>• Providing training to staff regarding Justice system needs and solutions and coordinating training initiatives with community partners<br>• Coordination with legal aid |
| **Post-Adoption Administrator** | • Collaborates with WV Foster Adoptive and Kinship Parents Network<br>• Facilitates advisory groups with adoptive/kinship families to obtain input and recommendations<br>• Implements solutions to mitigate risk of post-adoption disruptions |

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# Care coordination tiers, service levels, and clinical models [CM02, CM07, CM09, CM14, CM22]

| | |
|---|---|
| CM02 | The Vendor should share all information required for continuity of care with the member and their family or caregiver(s).<br>The Vendor should describe how it will meet this specification, including, but not limited to, communication paths, methods, and/or frequency. |
| CM07 | The Vendor should monitor members' physical and/or behavioral health needs and respond to changes in acuity over time, at the intervals determined for the populations eligible for medical services. Risk Levels based on acuity are outlined in Appendix 3: Service Provider Agreement.<br>The Vendor should describe how it will meet this specification.<br>The Vendor should:<br>1) Describe its protocol for assigning members.<br>2) Describe its proposed clinical, social, or other criteria.<br>3) Provide the expected time frame for care coordinator assignment to the identified member. |
| CM09 | The Vendor should assign an initial risk stratification tier within the first 30 days of enrollment. For those enrollees who require Intensive Care Management (ICM) the Vendor should determine the composition of the ICM team and develop a care plan specific to each case for members with one or more chronic conditions.<br>The Vendor should also review all treatment plans for members placed in a Residential Mental Health Treatment Facility (RMHTF) or Psychiatric Residential Treatment Facility (PRTF) at a minimum of monthly to ensure appropriate treatment and participate in meetings with the RMHTF or PRTF as requested by the Agency. The Vendor should also complete a 90 day review of the treatment plan to assess appropriateness of a discharge to a less restrictive setting.<br>The Vendor should describe how it will identify children/youth who exceed Level 3 needs and any children/youth who require a more intensive care management strategy to address complex cases, high priorities, children dually involved in the child welfare and juvenile justice systems, and/or if BSS determines the need. |
| CM14 | The Vendor should provide a care coordination model with stratified services for members according to clinical, social, or other Vendor-proposed criteria as approved by the Agency. The Vendor should facilitate coordination of care between primary care providers (PCPs) and any other providers that the child is working with to include, but not be limited to, the children's behavioral health, specialty, vision, and dental providers for populations eligible for medical services, This includes, but is not limited to, children with special healthcare needs.<br>See Appendix 3: Service Provider Agreement, 6.3.2 Coordination of Care for more information on coordination of care and risk stratification expectations.<br>1) The Vendor should provide a detailed description of its care coordination model.<br>2) The Vendor should describe how the care coordination department is organized and the integration of the service types.<br>3) The Vendor should describe its proposed clinical, social, or other criteria to be used for member stratification.<br>4) If applicable, the Vendor should include an explanation of how the Vendor will work with other parties to administer this care coordination, including, but not limited to, subcontractor(s) and affiliate advocacy group(s).<br>Note: The Agency expects all members to be eligible for care coordination services. |
| CM22 | The Vendor should establish and implement guidelines for how often the care coordinators will contact members after initial care coordination contact, based on the member's acuity level. The Vendor should include guidelines for care coordinators to have face-to-face contact with their assigned members, including, but not limited to, when requested by an Agency worker. Outreach frequency should correspond to acuity. Risk Levels based on acuity are outlined in Appendix 3: Service Provider Agreement.<br>The Vendor should describe its approach to care managers' face-to-face contact with assigned members, including, but not limited to:<br>1) Frequency<br>2) Circumstances resulting in a need for face-to-face contact<br>3) Goal of face-to-face contact at this frequency and/or in these circumstances |

We designed our care coordination model upon a foundation of:

- Assignment of members to care management tiers based on clinical and SDoH needs
- Providing care coordination at different levels of intensity, depending on the assigned care management tier
- Overarching, evidence-based clinical models

## Care management tier criteria and services [CM02, CM07, CM09, CM14, CM22]

**All members are eligible for care management services,** and we screen and stratify them into one of three levels of care management that meets their specific, holistic needs. We use our screenings, clinical assessments, evaluation of SDoH, and risk stratification model, to determine which care management level (intensive, supportive, or population health) will best provide each member with integrated, whole-person care. The table below **describes the clinical and SDoH criteria for each care management tier.**

| Care Management Tier | Clinical and/or SDoH criteria |
|---|---|
| **Intensive Care Management (Tier 3) CC to member ratio: 1:17** | • Children entering foster care<br>• Individuals with multiple complex chronic conditions, comorbidities, or co-occurring conditions, special health care needs, medically complex [CM09]<br>• Individuals with three or more ED visits or previous behavioral health inpatient admissions<br>• Pregnant women with a history of substance use or who are currently using substances<br>• Pregnant women with current or historical high-risk pregnancy<br>• Infants with neonatal abstinence syndrome<br>• Children and young adults with abuse and/or trauma histories with significant SDoH needs or with other complex diagnoses<br>• Adults and adolescents who are homeless or have a history of residential instability (four or more residences over the past year)<br>• Children with serious emotional disorders<br>• Individuals with HIV/AIDS, cancer, chronic renal failure, and other chronic complex conditions |
| **Supportive Care Management (Tier 2) CC to member ratio: 1:36** | • Moderate acuity, not at risk of crisis<br>• Individuals with ambulatory care sensitive conditions or a disease management condition (e.g., asthma, chronic heart failure, chronic obstructive pulmonary disease, diabetes, or depression)<br>• Referrals from within the plan or a provider that shows care coordination or service needs and/or readmission risks |
| **Population Health Care Coordination (Tier 1) CC to member ratio: 1:350** | • Individuals with limited health care needs<br>• All members with chronic conditions needing ongoing surveillance and support identified for care management and not enrolled in Tier 2 or Tier 3<br>• Members who are able to self-manage condition(s)<br>• Member showing improvement who moved from Tier 2 to Tier 1 |

The frequency and intensity of care management interventions differ depending on the needs of the child and the care management tier to which they are assigned. The table below outlines the methods and minimum frequency of member/family/guardian contact and communication expectations and services provided in each care management tier for care coordination purposes. The table below shows Aetna Mountain Health Promise Care Coordination Services by Tier [CM02, CM14, CM22]

| Care Management Tier | Services Provided |
|---|---|
| **Intensive Care Management (Tier 3)** | • One face-to-face visit (monthly), and as requested by the Department or member/family/guardian<br>• One weekly contact |

| Care Management Tier | Services Provided |
|---|---|
| **CC to member ratio: 1:17**<br>**Current member count: 1,041** | • A minimum of two hours per week of care coordination<br>• One meeting with the interdisciplinary care team(monthly)<br>• One care plan update (monthly)<br>• Attend MDT, when invited by DHHR |
| **Supportive Care Management (Tier 2)**<br>**CC to member ratio: 1:36**<br>**Current member count: 750** | • One face-to-face visit (quarterly), and as requested by the Department or member/family/guardian<br>• Biweekly/monthly calls/contacts<br>• One meeting with the interdisciplinary care team (every 90 days)<br>• One care plan update (monthly)<br>• Attend MDT, when invited by DHHR |
| **Population Health Care Coordination (Tier 1)**<br>**CC to member ratio: 1:350**<br>**Current member count: 27,122** | • All West Virginia members have access to care coordination services and a Care Connection teams<br>• Outreach West Virginia members quarterly to assess any changes in social risks, health conditions, or any other need<br>• One meeting with the interdisciplinary care team every 90 days by regional supervisor<br>• Educate members and their caregivers on how to contact the health plan should needs arise prior to outreach<br>• Health risk assessment (HRA) is completed (at least annually)<br>• Health education screenings<br>• Attend MDT, when invited by DHHR |

The American Academy of Pediatrics (AAP) has identified children in foster care as having special health care needs. They often come from biological families with high rates of SUD, mental health issues, unemployment, violence, and poor parental skills. Once in foster care, children may experience inconsistent health care, frequent placement changes, or barriers to accessing services that result in escalated medical situations and a higher prevalence of developmental, educational, or behavioral concerns. Likewise, children enrolled in the CSED waiver have complex behavioral health needs. For these reasons, we initially assign most children in foster care and CSED to Tier 3 intensive care management. If ongoing reassessment and care planning updates show that the child's situation has stabilized or measurable progress toward goals have occurred, a child in foster care or CSED in Tier 3 care management may transition to Tier 2 care management.

[CM09] Our **Intensive Care Management (ICM) teams include the full complement of our Care Connection team staff:** care coordinators, SUD specialists, and our peer support specialists and community health workers when needed. Clinical care coordinators (nurse CMs or licensed behavioral health CMs, depending on each child's needs) facilitate ICM teams. The larger interdisciplinary care team, inclusive of members and their families/caregivers/guardians, providers, and caseworkers, participates with the ICM team when the clinical care coordinator facilitates ongoing care planning and coordination. At times, CAT administrators may participate in care planning with the ICT as needed to identify creative strategies to removing barriers to access, as they may be aware of new, emerging community resources.

Our care management approach is responsive to members' changing needs. As we monitor members' life circumstances and progress towards goals in ongoing assessment and care planning, should we identify a member in Tier 3 with even greater needs than what we typically provide in ICM, we scale up our interventions and frequency of contact on an ad hoc basis for as long as necessary to meet the member's changing level of need.

## Care management clinical models [CM14]

While the types and frequency of care management services we provide may differ depending on the care management tier to which a member is assigned, all our care coordination efforts align with the clinical models we have adopted for members in the Mountain Health Promise program. These include:

- Wraparound-informed care
- Charting of the LifeCourse framework
- Safe at Home
- Family Finding

### The Wraparound Model

In West Virginia, we employ wraparound-informed strategies to build constructive relationships and support **community-based, culturally relevant, family-centered services for children with emotional or behavioral health concerns** and their families. This model is **particularly useful to members enrolled in the CSED waiver program** and their provider care managers serve as wraparound facilitators in collaboration with Aetna care coordinators. Care plans are comprehensive and address multiple life domains across home, school, and community, including living environment, basic needs, medical needs, safety, and social, emotional, educational, spiritual, and cultural needs among others. If interventions are not achieving the outcomes desired by the member, their circle of support, and the ICT (or Child and Family Team), the ICT/CFT regroups to rethink the configuration of supports, services, and interventions to ensure success in natural home, school, and community settings. In other words, children do not fail, but plans and providers can fail a child. **Rather than forcing a child to fit into existing program structures, wraparound is based on the belief that services and supports should be flexibly arranged to meet the needs of each child and their family.** We integrate a large collaborative network to meet the child's need and ensure the right people are at the table in the child and family-centered care-planning process. Collaborators may include families, primary and specialty providers, child advocates defense attorneys, law enforcement, probation officers, case workers, and educational officials.

All children deserve a permanent home. Care coordinators using the wraparound model work with parents and caretakers to help alleviate the issues of the family, such as abuse and neglect—**things that caused removal from home and placement in the custody of the state. If a child can be returned safely to the home, then the best place for the child is in the home.** Wraparound, a community-based model that builds on a family's strengths is used to empower the family to achieve a level of change required for reunification. If a child cannot be safely reunited with his or her family, services are provided to find and support other permanency options, such as guardianship or adoption. Care coordinators facilitate all services necessary to **support the permanency goal** for the children in care. In collaboration with referral sources, care coordinators provide for safety and needs assessments, resource acquisition, transportation and visitation, court reports, and authorization of funds for services to family members across multiple life domains.

As part of our Wraparound Informed Model, we will implement a **Shared Parenting Program** that purposefully engages the biological family in the active care of their child while in foster care. We recognize that biological parents and their children experience grief and loss at the separation when a removal into out of home care occurs. **A parent needs to know their child is being well cared for and the child wants to know their parent is okay.** Parents need support, assistance in navigating the system and help understanding the needed changes and supports to safely parent their child. They

may need substance use treatment or behavioral health treatment. They may need help with housing, food security, job obtainment, parenting classes, support dealing with partner violence, and other needs. To help support the family, we will connect them with a **Parenting Peer Support specialist** who will engage the biological family, in collaboration with the Care Connection team, to assess for resource needs, provider needs, and service needs. As a member of the ICT, the peer support specialist will help connect them to resources and ensure the family is engaged in their child's care as much as the DDHHR case worker is allowing to safely occur. As appropriate, our Parenting Peer Support specialist will discuss with the DHHR case worker the potential to refer the family to SNS to meet their needs. The responsive and flexible wraparound model ensures family voice and choice leading to effective outcomes and permanency over time.

Our **Better Together Social Care** team will also engage with biological families of children in foster care to offer navigation and support in connecting with social services to address SDoH. Social Care staff use our **Community Resource Directory (CRD)** to identify and connect families to both local and national available resources. The team ensures follow-up to support loop closure on all referrals. The CRD database includes nearly **4,792 West Virginia-based resources and 857,000 national resources.**

We will supply informational materials about our Shared Parenting and Social Care programs to courts, BSS caseworkers, and community-based organizations to ensure biological families are aware of the availability of these services. Additionally, upon BSS permission, the parenting peer support specialist will outreach the family to assess their needs and inform them of these programs.

### Charting of the LifeCourse

We use the Charting of the LifeCourse (CTLC) framework's tools and resources to support the wraparound foundational model of care. **CTLC serves youth in foster care and juvenile justice systems**, in concert with their circle of support. CTLC guides youth to **consider what is predictable as preventable.** It encourages members to think about the impact their health has on their life story and vice versa. We know that if we can predict difficulties, we can collaborate to prevent them. CTLC assists members in recognizing their challenges and helping to navigate and resolve them. **More than 30 of our care managers have received specialized training in CTLC**. We designed our electronic care management platform to include and **track the utilization of more than 200 CTLC intervention types** in member care plans and have used these interventions more than 400 times in 2022 so far.

### Safe at Home




We support the use of **trauma-informed wraparound services,** such as the Safe at Home approach for children and youth, especially for children enrolled in the CSED waiver before they have established permanent waiver services. Safe at Home places recognizes the impact of trauma and on family engagement in service planning. Care planning is conducted with the goal of keeping children and youth in their homes and communities when it is safe to do so. **Safe at Home is critical to reduce foster care and congregate care and to prevent re-entries. Additional goals include the reduction of the placement of children in out-of-state services and increase in the step-down of youth from placements and/or reunification with family**. These goals are achieved via trauma-informed assessments and delivering trauma-informed care.

## Family Finding

The Family Finding approach promotes member safety and well-being through **strengthening family connections and support networks.** The more a family is engaged to build support and resilience within their own network and share in the responsibility for safety, permanence, and well-being of the child, the greater the likelihood that child welfare/protection services will be shorter and more effective. Family Finding stresses the importance of including family in decision making for the young person, ensuring they have a seat at the table. Meaningful Family Finding activities include the following:

- Location and engagement with supportive people to help parents care for the child in their home, before out-of-home placement is needed or for reunification
- Exploration of whether there are known/kin supports available, should out of home care be needed
- Maintaining/finding connections for young ones in foster care
- Looking for permanency options within the family
- Building social history information
- Connecting youth aging out of care

We have engaged with more than **200 children in Family Finding activities.** We also offer monthly Family Finding orientations and four bootcamp trainings per year for stakeholder caseworkers who work with children and families. Additionally, we provide **Family Finding coaching to BSS caseworkers** to help them build support networks for members and identify tools which might be beneficial to use if the network cannot be built organically. We are implementing a train the trainer for the Family Finding model to increase the number of internal and provider staff who can employ Family Finding approaches.

The clinical models we employ collectively ensure that we consider each child and family's individual circumstances and needs while supporting active coordination with providers, state agencies, and the community stakeholders, which inform the integrated care plan.

Figure E.2-3 offers a summary overview of our care management process flow, from initial engagement and screening to creation of the care plan and ongoing follow up, which we will now describe in detail throughout the rest of this response.

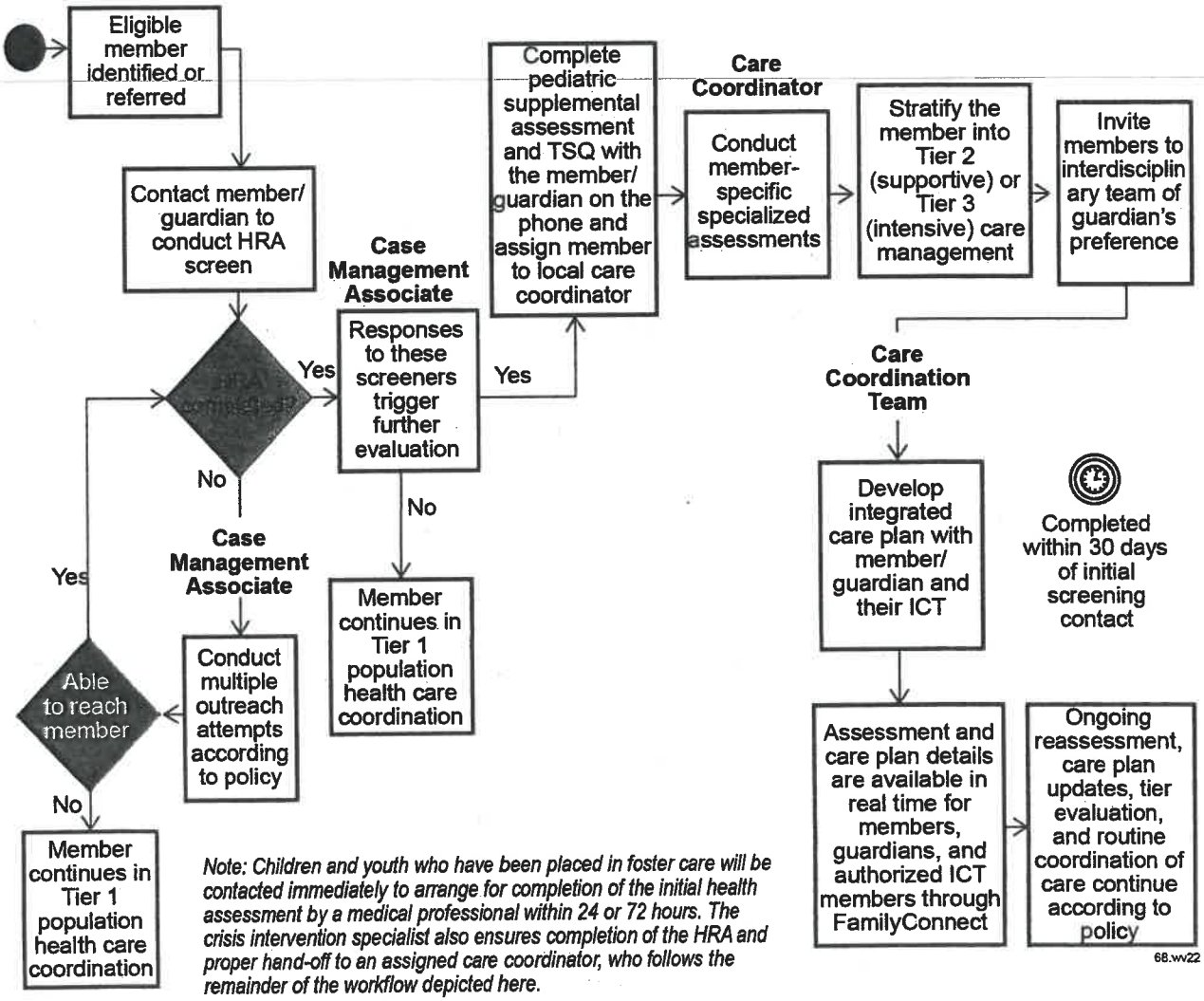



***Figure E.2-3:*** *Our care coordination process quickly connects members and their families/guardians to an assigned local care coordinator who facilitates ongoing assessment, care planning, and coordination.*

## Engaging with members to initiate care management [CM01, CM07, CM09, CM11, CM15, CM17, CM19, CM21, CM27]

| | |
|---|---|
| **CM01** | The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated Vendor care plan for all children. Additionally, the Vendor should identify individuals with complex or serious medical conditions, including, but not limited to, CSED, on an ongoing basis and track members with high physical and/or behavioral health needs to assure continuity of care.<br>The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.<br>Information on the WV CSEDW can be found at the following link:<br>dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx |
| **CM07** | The Vendor should monitor members' physical and/or behavioral health needs and respond to changes in acuity over time, at the intervals determined for the populations eligible for medical services. Risk Levels based on acuity are outlined in Appendix 3: Service Provider Agreement.<br>The Vendor should describe how it will meet this specification.<br>The Vendor should:<br>1) Describe its protocol for assigning members.<br>2) Describe its proposed clinical, social, or other criteria. |

| | |
|---|---|
| | 3) Provide the expected time frame for care coordinator assignment to the identified member. |
| CM09 | The Vendor should assign an initial risk stratification tier within the first 30 days of enrollment. For those enrollees who require Intensive Care Management (ICM) the Vendor should determine the composition of the ICM team and develop a care plan specific to each case for members with one or more chronic conditions.<br>The Vendor should also review all treatment plans for members placed in a Residential Mental Health Treatment Facility (RMHTF) or Psychiatric Residential Treatment Facility (PRTF) at a minimum of monthly to ensure appropriate treatment and participate in meetings with the RMHTF or PRTF as requested by the Agency. The Vendor should also complete a 90 day review of the treatment plan to assess appropriateness of a discharge to a less restrictive setting.<br>The Vendor should describe how it will identify children/youth who exceed Level 3 needs and any children/youth who require a more intensive care management strategy to address complex cases, high priorities, children dually involved in the child welfare and juvenile justice systems, and/or if BSS determines the need. |
| CM11 | The Vendor should incorporate data about social determinants of health, as defined by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC) into its care coordination services.<br>The Vendor should describe how it will meet this specification |
| CM15 | The Vendor should assign members to an appropriate healthcare professional who is formally responsible for coordinating the member's overall healthcare, including, but not limited to, behavioral health for populations eligible to receive medical services.<br>The Vendor should:<br>1) Describe its protocol for assigning members.<br>2) Explain how the Vendor proposes to define an "appropriate" healthcare professional.<br>3) Specify whether services are coordinated by the member's primary care provider (PCP) or through some other means, including, but not limited to, a care coordinator.<br>4) Address how it will ascertain member choice and weigh it into its assignment. |
| CM17 | The Vendor should perform screening, assessment, and/or utilization analysis to identify and provide needed services to members and/or their caregivers(s), including, but not limited to, assessments of members with special healthcare and behavioral health needs.<br>1) The Vendor should describe its methods for meeting this specification.<br>2) The Vendor should describe any additional screening tools used in this process.<br>3) The Vendor should provide a health risk assessment template and the protocol for completing each member assessment. |
| CM19 | The Vendor should use specialized care coordinators for certain conditions, including, but not limited to, experienced pediatric or cardiac nurses and behavioral health specialists.<br>The Vendor should indicate how the Vendor will use specialized care coordinators for certain conditions and describe the rationale behind its approach. |
| CM21 | The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members. See Appendix 3: Service Provider Agreement for additional information on the role of care coordinators.<br>The Vendor should describe in detail:<br>1) Steps care coordinators will take to establish relationships with their assigned members.<br>2) A protocol for addressing a member who does not want a care coordinator or cannot be reached once a care coordinator has been assigned. |
| CM27 | The Vendor should develop a process to identify and manage the care of members that are transferring from juvenile justice facilities to foster care placements.<br>The Vendor should describe how it will meet this specification. |

We engage in initial care coordination activities to promptly:

- Identify members who are newly enrolled in our plan
- Conduct initial health screenings of all members
- Assign members to a care coordinator
- Conduct additional comprehensive assessments
- Confirm care management tier assignments through ongoing predictive risk stratification

## Initial identification of new members [CM01, CM27]

We use the following data sources and processes to identify newly eligible members, **including those with complex medical or behavioral health needs:**

- We review daily Families and Children Tracking System (FACTS)/daily 834 files which provide full access to foster care member information including foster care contacts, BSS and placement information, medications, last appointments, providers, and diagnoses; we will utilize PATH notifications to identify new members as soon as it is implemented by the state.
- In weekly meetings with BJS and during discharge planning for members in BJS placement, we identify new members and help members and their circles of support with discharge planning even before they become enrolled in Mountain Health Promise [CM27].
- We access Kepro's daily files which include the CSED rate code attribute to identify children in the CSED waiver program [CM01].
- We conduct further research on the history of members' care via the West Virginia Health Information Network (WVHIN) which offers prior medical history, testing, pharmacy, labs, and other pertinent clinical information that identifies complex medical or behavioral health needs [CM01]; we access the WVHIN through our population health management platform.

## Initial screening of new members [CM09, CM11, CM17]

**Immediately upon receipt of enrollment notification,** we outreach members and their families/guardians to conduct an initial health risk screening (health risk assessment), utilizing Motivational Interviewing techniques, to identify members' needs and risk factors and determine an initial care management tier stratification [CM09]. We aim to complete these processes within 30 days of enrollment. We conduct re-screening on an annual basis (or as the member's life or health circumstances change).

**Health risk assessment for members enrolled due to adoption or CSED eligibility:** Upon notification of enrollment of any new member (based on notification via Department 834 files), we conduct outbound outreach as a first attempt to complete the health risk assessment (HRA) with the member and their family/guardian/caseworker and/or attorney. Members in the Mountain Health Promise program may have, or may be at high risk for, a chronic physical, developmental, behavioral, social, neurological, or emotional condition requiring a broad range of evidence-based primary and specialized medical or behavioral health, and/or related services [CM17]. **We have tailored the HRA to screen for the types of issues Mountain Health Promise members/families experience.** For example, we include questions about past utilization of health services, household opioid prescriptions, whether the child misses school for reasons other than illness, and whether the guardian needs special assistance to hear or communicate effectively. **The HRA also includes 11 questions related to SDoH** [CM11]. We disclose to the member and their guardian how we will use the information gathered in screening tools. The HRA is available in English and Spanish, at a reading level no higher than sixth grade, and can be completed via multiple avenues based on member and family needs. The table below identifies the areas we ask about in the initial HRA screening.

| Domains | |
|---|---|
| • Confirmation and review of basic demographics<br>• Preferred language read/spoken<br>• General health and emotional health [CM17]<br>• Condition-specific questions | • Medications<br>• School attendance<br>• Functional question<br>• Smoking history<br>• Pregnancy status |

**Domains**

- SDoH concerns (food, transportation for accessing health care, housing and utilities, education, employment, social/community connectedness [CM11], and interpersonal/neighborhood safety concerns [CM11]
- Utilization of services (PCP, DDS, Behavioral Health, PT, OT, etc.) [CM17]
- Determination of whether anyone in the home has an opioid prescription
- Screening related to emotions, learning, focusing, behavior, and services in the home in the last 12 months

Figure E.2-4 displays our HRA template [CM17].

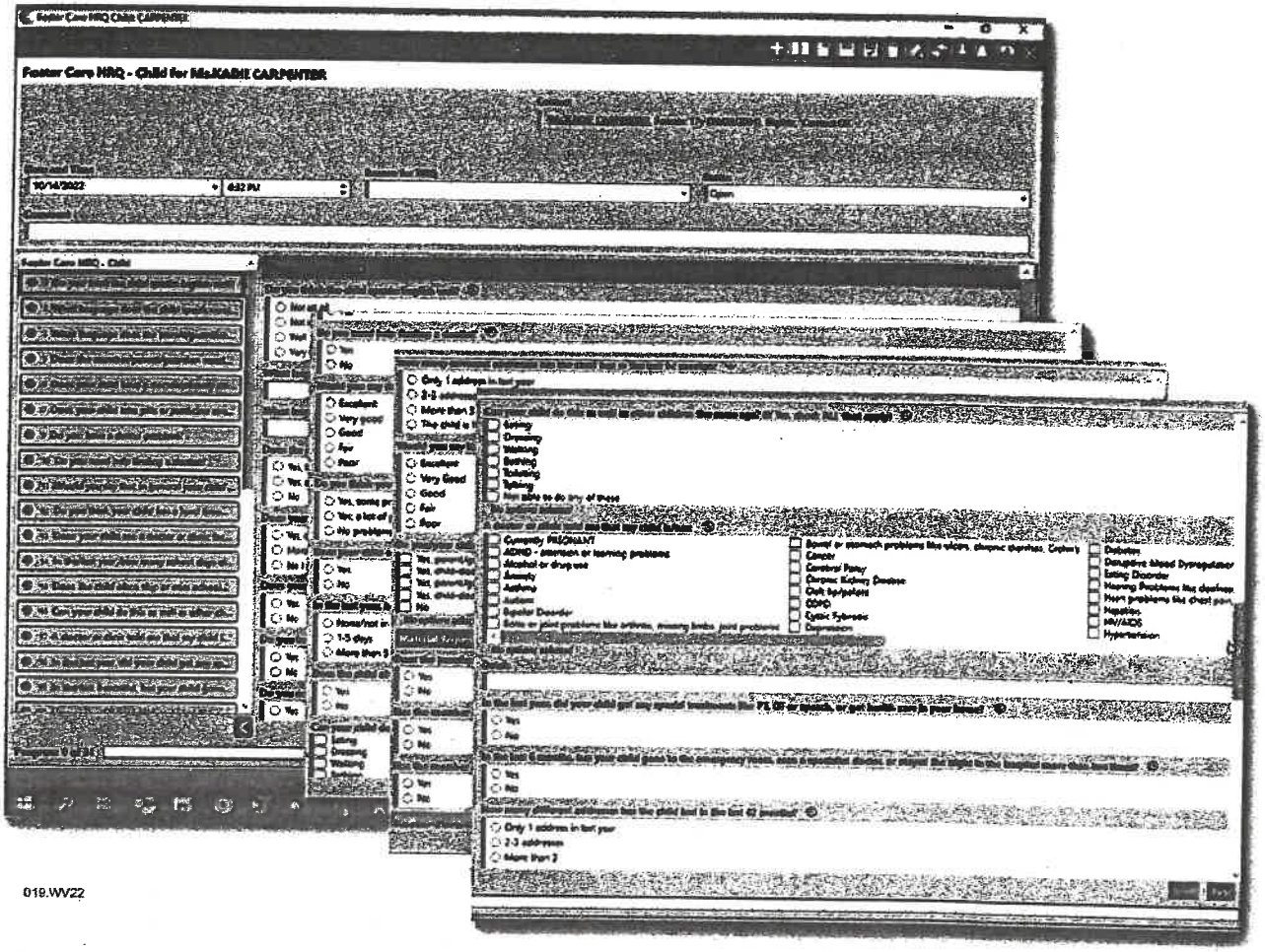
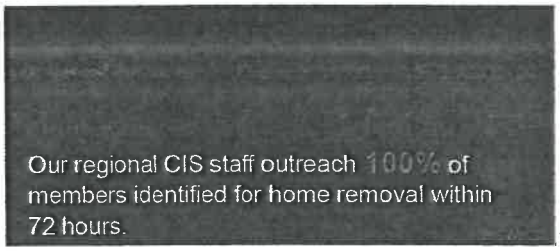



***Figure E.2-4: HRA template.*** *We utilize our HRA as our initial health risk screening tool.*

For all members of our Mountain Health Promise plan, we use multiple strategies including in-person navigation if needed to **maximize completion of the initial HRA**. These include multiple phone outreach attempts, followed by letters to the guardian/caseworker, and other demographic research as needed to find the correct contact information. For example, we work with local hospitals for members discharged from an inpatient setting to obtain contact information. Care management staff also use medical, behavioral health, and pharmacy claims as well as admission, discharge, and transfer (ADT) data from the WVHIN to identify contact information which may improve success in reaching the member and their guardian to complete the screening. **At present, 75% of all members in our Mountain Health Promise program to date have completed the HRA; 84% of CSED members have completed the HRA.** We offer additional mechanisms to complete the HRA if it cannot be completed through processes described previously:

- **Member portal:** Members may complete the HRA in the member portal
- **Population health management platform:** An alert through our electronic population health management platform notifies member services representatives to warm transfer the call to care management staff for completion of the screening to determine if they may benefit from a higher level of care management
- **Peer support specialists and/or community health workers:** May contact members to complete the HRA
- **Mobile application:** Members can complete the HRA through our secure mobile application which feeds directly into our electronic care management system.
- **HRAs completed in the community**: The HRA tool is available for completion with embedded care coordination staff at BSS offices and other provider locations

[CM09] **The HRA screening process allows for initial and immediate member stratification** to either Tier 1 population health care coordination or to additional assessment and determination of referral to Tier 2 (supportive) or Tier 3 (intensive) care coordination based on care management tier criteria described earlier in this response. All members providing positive responses to any screening question on the HRA, who may have multiple chronic conditions, SDoH barriers, special health care needs, or those who are in foster care receive further assessment and stratification into the appropriate care coordination level (2 or 3). The care management associate completes an additional **Trauma Screening Questionnaire (TSQ)** during the initial screening call for members who stratify to Tier 2 or Tier 3. Upon completion of the TSQ, the care management associate identifies and warm transfers the member and their family/guardian to a care coordinator. Members that are assigned to population health care coordination (Tier 1) receive quarterly calls from care management associates, as well as educational mailings. Members that are assigned to a care coordinator for Intensive (Tier 3) or Supportive (Tier 2) care management receive further assessment, care planning, and general care coordination activities.




**Initial health risk screening and preliminary connection to services for children placed in foster care**: State workers notify our Crisis Intervention Specialist (CIS) when a child or children are being placed in either a foster home, a relative home, or a facility, within 24 hours of the decision to remove the child from a biological family. Through our **First in Care Program**, our CIS begins helping the member/family, even if the child does not become a foster child but is placed out of their home of origin with family and is enrolled with Aetna. The CIS outreaches the family/caregiver/placement to ensure we obtain medical records related to previous medical history and treatment (including vision and dental), as well as immunizations. They also help the family/caregiver/placement and state worker select a medical health home and schedule the member's first medical appointment.

**Our CIS completes the HRA with the member/family/foster placement and their BSS caseworker.** They support the member, foster placement, and BSS caseworker during the first week following notification of placement to ensure proper connection to services and to identify and address immediate needs, which may include items such as bedding, car seats, clothing, school supplies, meals through our value-added services program, and any items to assist the child moving into their home. **The CIS ensures member/family connection to their assigned Tier 3 ICM care coordinator**. This CIS

provides a telephonic report to the assigned ICM care coordinator so they may facilitate continued assessment, follow up with the medical professional who completed the IHS, care planning, and ongoing coordination and continuity of care.

## Assignment to a care coordinator [CM07, CM15, CM19, CM21]

**The thoughtful matching of a member to a dedicated care coordinator,** based on the member's condition(s) and the tier-based criteria described earlier in this response, **serves as the foundation for building positive relationships with members and successful care planning and ongoing coordination** [CM21]. **Upon completion of the HRA (which we attempt to achieve within 30 days of enrollment), we assign all members to a local care coordinator**, who is supported by the other Care Connection team staff, peer support specialists, community health workers and CAT administrators. [CM07] We pair members with care coordinators whose expertise, credentials, and training are aligned to the clinical and social needs of the member. [CM19] For example, we assign children that are deemed medically complex, or infants with a diagnosis of NAS to a registered nurse care coordinator in ICM Tier 3. Pediatric nurse CMs with cardiology experience are assigned to members who have heart conditions. We match children with a behavioral health diagnosis or behavioral health claims with a licensed behavioral health care coordinator. We assign siblings within a family to the same care coordinator whenever possible and **honor member preferences** related to having a care coordinator with specialize experience in LGBTQ issues. We assign members to care coordinators who work and live in the member's community and who have contacts with local partners and providers to coordinate care. Care coordinators who are knowledgeable of the health disparities of the region deliver face-to-face and telephonic care management services. We respect member choice and if a member/family/guardian requests a different care coordinator from the one initially assigned, we will assign them to another well-matched care coordinator.

To **introduce the member/family/guardian to the assigned care coordinator following initial completion of the HRA and TSQ**, the care management associate can immediately transfer them to the assigned care coordinator or have the care coordinator call them back, whichever they prefer. In either case, the care management associate provides the member and their family/guardian with the care coordinator's contact information. Additionally, they explain the care coordinator's role and what the member/family/guardian can expect as care coordination continues. The care management associate ensures the assigned care coordinator has all the screening and other preliminary information obtained during the initial screening contact process.

[CM15] The **assigned dedicated care coordinator acts as a single point of contact** for the member/family/guardian going forward and is responsible for relationship development [CM21] and coordination of care for all necessary physical health, behavioral health, functional, and wraparound social support services. **The assigned care coordinator works in close contact with the member's PCP, who also has a leadership role in the care planning and coordination process.**

Our screening tool does allow for adopted members/guardians to opt out of care coordination, if they choose, although we continue outreach every six months to identify new needs and remind them that care coordination is available to help. The option to opt out is also in the welcome letter that we send to members and their guardians. In conversation and in our letters, we provide the contact number for member services and the Care Connection team for the members/guardians who have opted out to contact should the family later decide to engage in care management services [CM21].

## Additional comprehensive assessments [CM01, CM17, CM21]

We recognize that youth and families may become overwhelmed with providing responses to various screeners and assessments. This is particularly true for juvenile justice-involved youth who may receive specialized risk/need assessments in the courts or DJJ. **In an effort to reduce the recounting of trauma associated with answering questions on multiple assessments/screeners, as well as to reduce duplicative efforts,** the member's care coordinator reaches out (with the authorization of the member's guardian) to child welfare agencies currently working with the child and their family, as well as previous providers, facilities, and sister agencies to obtain the information that can be used to complete additional assessments and screeners beyond the HRA and TSQ. [CM01]. They incorporate this information into the member's file, ensuring access to this information when needed. We also review and incorporate details from the CAFAS (completed by providers) to inform care planning and assess for discharge opportunities.

We use the information from these sources, as well as information we obtain in completing our **Pediatric Supplemental Assessment** with members to understand the member's overall health care needs, conditions, and service history. [CM17] When there is a need to conduct additional condition-specific assessments, the assigned care coordinator schedules an appointment with the member/family/guardian to complete these additional assessments in person within 30 days of completion of initial screenings. **Currently, 93% of assessments are completed within 30 days of the HRA.**

We use a range of assessments to evaluate the types of conditions and issues members of the Mountain Health Promise program are most likely to experience. Due to their training in the field, care coordinators use their professional knowledge and information regarding the member's life and health experiences to decide which specialty assessments to conduct to **ensure we assess all potential special health care needs**. In addition, care coordinators use an algorithmic approach to choosing screening options. As initial screenings such as the HRA and TSQ are entered into the electronic care coordination system, the responses display in other assessments with the same/similar questioning. The system provides suggestions to care coordinators about additional detail to solicit during the in-person comprehensive assessment process. **We educate care coordinators on spending time efficiently with members, and by skillfully using motivational interviewing, they obtain the information necessary to complete special assessments without overburdening members with multiple questions.** Throughout the assessment process, care coordinators utilize tested member and family-centered approaches and motivational interviewing techniques to build strong relationships with members and their families/guardians [CM21].

### Assessment of trauma

Care coordinators use the Pediatric Supplemental and ACES-Q during the comprehensive assessment to identify trauma (in addition to the TSQ which would have already been completed during their initial screening).

### Assessment of behavioral health needs

**It is estimated that upwards of 80% of children in foster care have a significant mental health need.** A comprehensive assessment of all potential special health care needs must include thorough evaluation of behavioral health. For members responding positively in the screening to questions related to emotional or behavioral health needs, the care coordinator completes evidence-based assessments and screenings to evaluate behavioral health concerns, including the following [CM17]:

- CRAFFT

- Patient Health Questionnaire-9
- Psychosocial Pediatric Symptom Checklist 17
- Generalized Anxiety Disorder 7
- Edinburgh Postnatal Depression
- Depression Assessment
- Adverse Childhood Screening Assessment
- Trauma Screening Questionnaire

### Assessment of chronic conditions

Care coordinators use their clinical expertise and knowledge of the member's health to identify which condition specific assessments to complete. The following is an example of some of the condition specific assessments we use to identify special health care needs [CM17]:

- Diabetes assessment
- Hepatitis-C assessment
- HIV assessment
- Infant assessment
- Interval assessment
- Adult asthma assessment
- Pediatric asthma assessment
- Chronic Obstructive Pulmonary Disease assessment
- Cancer assessment
- Heart Failure assessment
- Hypertension assessment
- Sickle Cell assessment
- Coronary Artery Disease assessment
- Perinatal assessment
- Weight management assessment
- Lead assessment

With the authorization of the member's guardian, **we share all screening and assessment results** through the care plan, in real time (or upon Department request), with the member's assigned state caseworker via our **FamilyConnect** care coordination system, which leverages their electronic health records. Members/families/guardians can also access this information, as well as appointment information, in FamilyConnect. Providers access this information through the provider portal, but we can also send them results by mail or securely via email upon request, as authorized by the guardian. **In the future, we plan to offer residential treatment providers with access to FamilyConnect.**

The care coordinator utilizes information gained through the assessment process to confirm which care management tier best meets the needs of the member based on our care management tier criteria and assigns the member to the appropriate tier. The screening and assessment process lays the foundation for the creation of the member's initial care plan. We also conduct **ongoing repeat screening and reassessment** annually, at a minimum, or as triggered by a change in the member's functional or health status, or a change in their placement or residence.

## Assessment of SDoH [CM11]

**We collect and utilize data regarding SDoH** (e.g., food and nutrition, housing, education, transportation, violence, social connections, and other determinants as defined by the Centers for Disease Control and Prevention **to drive care coordination and improve the health status of members**. First, we assess SDoH information through the HRA. In 2018, we began stratifying SDoH data across demographic characteristics to identify SDoH trends among members in the Mountain Health Promise plan. Through our partnership with **Socially Determined** we utilize **predictive modeling to anticipate the social risk of each member**, as well as the contextual risk in which they

live. We use a combination of member- and community-level demographic, claims, and social risk data to inform member-specific care coordination and interventions to improve population health. Information related to the member's SDoH is critical in the development of members' individual care plans.

We analyze SDoH data annually and on an ongoing basis to ensure member needs are met, and it informs the annual development of our proprietary Regional Health Profiles, Population Assessment, and Membership Profile where specific references to West Virginia member food, housing, transportation, and personal safety/domestic violence are addressed.

## Risk stratification [CM01, CM07, CM09]

While we initially evaluate risk during the HRA screening process to determine a member's preliminary care management tier assignment [CM09], we also incorporate our **proprietary Consolidated Outreach and Risk Evaluation 2.0 (CORE™)** risk analysis tool as we continue with members in their service delivery journey to reassess risk levels and medical complexity and confirm whether they are still in the appropriate care management tier as their circumstances change [CM01, CM07]. CORE 2.0 identifies members with complex or serious high health care needs who are the most likely to benefit from Tier 2 or Tier 3 care management based upon on **two dimensions of risk**:

- **Inpatient Admission (IP) risk** based on predictive model estimates of the likelihood of the member having an inpatient stay within the next 12 months
- **Chronic Illness and Disability Payment System and Medicaid RX (CDPS Rx)** score from models that predict future medical cost based on diagnoses and prescribed medications

CORE 2.0 also includes **Clinical Impact Factors**, key indicators of health care needs that drive risk and are actionable through care management interventions (e.g., ED risk, comorbidity, medication non-adherence, high prior cost, identified SDoH, and health care utilization).The CORE 2.0 algorithm draws data from medical claims, prescription claims, SDoH, and demographics and calculates a baseline risk score using the risk percentiles from the CDPS Rx and IP models, then adds additional weights from the clinical impact factors to create a single final score for each member. We stratify members into levels of care management services based on this final score, with a **higher score indicating a greater need for higher-tier care management.** CORE 2.0 provides more accurate risk scoring by creating cohorts of members with similar risk profiles grouped by categories of aide and demographics (such as children, members with behavioral health needs, members with long term services and support needs, etc.) We allow the weight of the clinical impact factors to vary by cohort grouping to reflect the importance of that factor for the cohort. These weights are calculated from the increased risk associated with members who have an impact factor present compared to members without that impact factor.

Figure E.2-5 below provides an example of the risk stratification process.

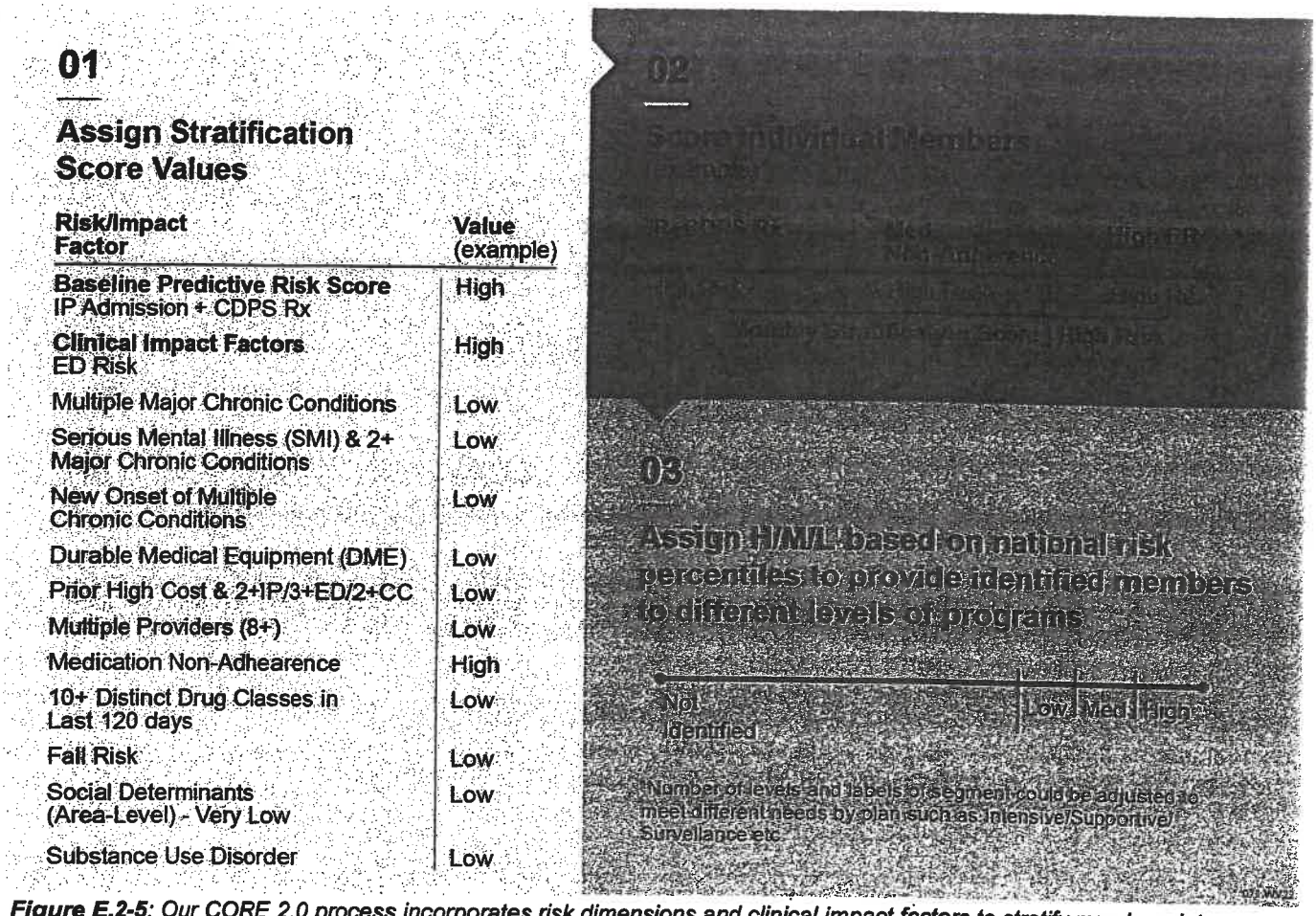



***Figure E.2-5**: Our CORE 2.0 process incorporates risk dimensions and clinical impact factors to stratify members into one of the three tiers of care management.*

**Rising risk model:** Early intervention is critical wherever possible, so we developed a **rising risk model to identify children and youth at risk for crisis episodes.** This practice allows the ICT to intervene at an earlier point with members to provide increased support and services to avert potential traumatic events including being placed out of their home. Our rising risk model uses **28 different measures to stratify and score members age 17 and under** including measures related to specific behavioral disorders, opioid use, physical/sexual/psychological abuse, self-harm claims, comorbidities, risk stratification score, engagement in care coordination, PCP assignment, frequency of changing PCP over the course of a year, total medical spend, ED utilization, pregnancy, justice system involvement, sexually transmitted disease diagnoses, household opioid use, household self-harm claims and household physical, sexual, or psychological abuse. Using this method, the care coordinator and ICT can rapidly identify members and who are at elevated risk that may need to receive services at a higher tier of care management. Once a member is identified for rising risk, the care coordinator outreaches the member and their guardian to further assess the situation and determine the next best course of action, including assignment to a higher tier if warranted. We do test our rising risk algorithms to verify there is no bias in risk stratification.

We have utilized this predictive modeling to drive targeted care coordination programs. For example, we identified children living in **Lincoln County** who were considered "rising risk" and are organizing a **care coordination program with school-based health centers** in the area to include a medical and

behavioral health provider, school counselor, social service provider, high risk youth specialist, community health worker and Aetna care coordinator to service these members.

## Care planning [CM01, CM04, CM11, CM12, CM14, CM24]

| | |
|---|---|
| CM01 | The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated Vendor care plan for all children. Additionally, the Vendor should identify individuals with complex or serious medical conditions, including, but not limited to, children with a serious emotional disorder (CSED), on an ongoing basis and track members with high physical and/or behavioral health needs to assure continuity of care.<br>The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.<br>Information on the WV CSEDW can be found at the following link:<br>dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx |
| CM04 | The Vendor should develop a process to engage the child/youth's caseworker, attorney representing the child, and other advocates as appropriate in the care planning process.<br>The Vendor should describe how it will meet this specification. |
| CM11 | The Vendor should incorporate data about social determinants of health, as defined by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC) into its care coordination services.<br>The Vendor should describe how it will meet this specification |
| CM12 | The Vendor should establish a process to develop Vendor care plans for all members with input from the member and their family. The Care Plan Team should be comprised of family members, the member, providers, the care coordinator, and an Agency lead.<br>The Vendor should:<br>1) Describe how it will meet this specification.<br>2) Explain how it proposes to define the "most appropriate" Vendor care plans. |
| CM14 | The Vendor should provide a care coordination model with stratified services for members according to clinical, social, or other Vendor-proposed criteria as approved by the Agency. The Vendor should facilitate coordination of care between primary care providers (PCPs) and any other providers that the child is working with to include, but not be limited to, the children's behavioral health, specialty, vision, and dental providers for populations eligible for medical services, This includes, but is not limited to, children with special healthcare needs.<br><br>See Appendix 3: Service Provider Agreement, 6.3.2 Coordination of Care for more information on coordination of care and risk stratification expectations.<br>1) The Vendor should provide a detailed description of its care coordination model.<br>2) The Vendor should describe how the care coordination department is organized and the integration of the service types.<br>3) The Vendor should describe its proposed clinical, social, or other criteria to be used for member stratification.<br>4) If applicable, the Vendor should include an explanation of how the Vendor will work with other parties to administer this care coordination, including, but not limited to, subcontractor(s) and affiliate advocacy group(s).<br><br>Note: The Agency expects all members to be eligible for care coordination services. |
| CM24 | The Vendor should identify members in need of a Vendor care plan and develop, update, and use clinically appropriate Vendor care plans that address coordination of primary services, specialty services, ancillary services, community and social supports, and/or carved-out services for members identified as having special healthcare needs, based on that member's needs.<br>1) The Vendor should describe the process and/or mechanisms for identifying members in need of such a plan.<br>2) The Vendor should describe in detail the process for developing, updating, and using these Vendor care plans.<br>3) The Vendor should provide a sample Vendor care plan. |

**All members** assigned to any level of care management tier regardless of which population they belong to (foster care, adoption assistance, legal guardianship, individuals with special health care needs, CSED) **receive care coordination and an individualized wraparound care** plan to meet their individual circumstances and needs and to ensure seamless access to services and trauma informed care. [CM14, CM24]. Here we describe the:

- The composition of ICT care planning teams,

- Care planning process
- What the member/family/guardian, care coordinator and ICT include in the care plan.

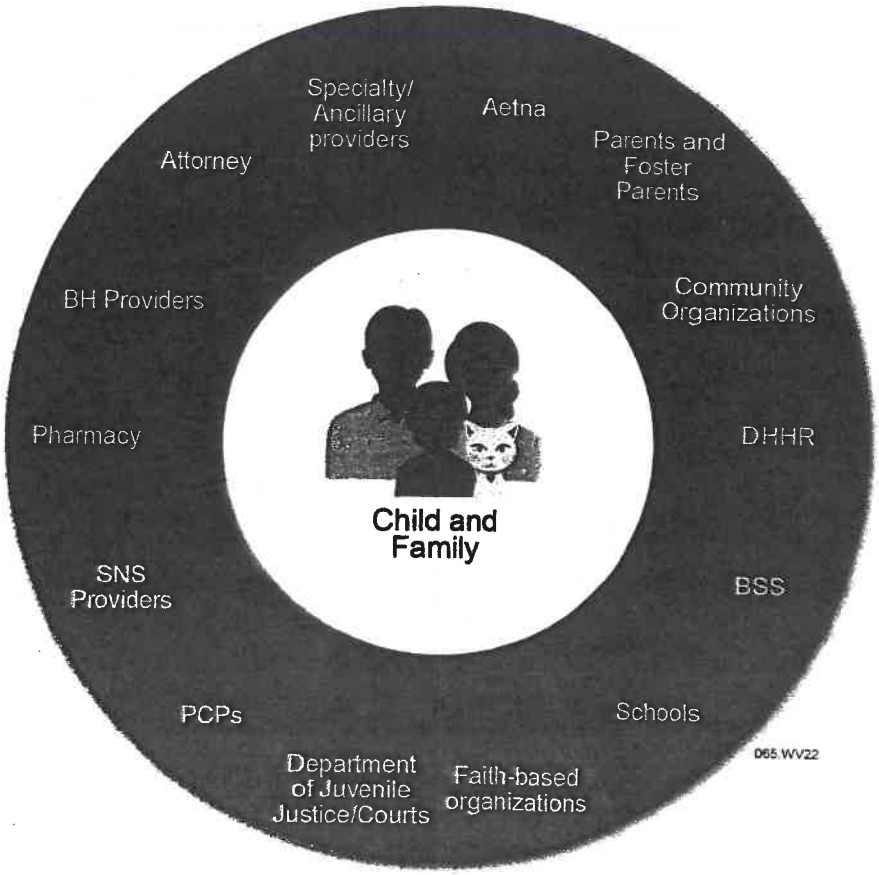



***Figure E.2-6: Interdisciplinary Care Team:*** *Members and their families/guardian can invite a variety of provider, stakeholder, and other circle-of-support representatives to participate in care planning on the Interdisciplinary Care Team.*

Care planning team participants [CM01, CM04, CM12, CM14]: Following completion of initial screening and assessments, **the member and their family/guardian identify the people they want on their interdisciplinary care team (ICT).** The member/family/guardian may choose to include any/all of the following for their ICT: the member's PCP/pediatrician, physical health, dental, behavioral health, specialty providers (including vision and dental), peer support specialist, community health worker, DHHR representative, BSS caseworker/child welfare provider, legal representative, other advocates, friends, adoption competent therapists, school representatives, juvenile justice representatives (if applicable), SNS providers, faith-based supports, the Aetna clinical pharmacy advisor, and other SUD specialists. Figure E.2-6 depicts the variety of potential contributors to the ICT and care planning process.

We aim to **operate ICTs with a 1:10 natural member-to-professional ratio** (per national wraparound standards) **to strengthen the impact of member and family voice and choice.**

**Care planning process and care plan content:** The most effective care plans are member-driven and provider-informed and ensure coordination of care and integrated services between medical providers, behavioral health providers, and child welfare providers to address the goals identified by the member and their family/guardian and circle of support. **The care coordinator facilitates the creation of the integrated care plan based upon input from the member, their family/guardian, and their ICT within 30 days of completion of the first screening contact with the member and their guardian [CM12].**

The wraparound and Shared Parenting model, LifeCourse framework, Safe at Home approach, and Family Finding activities guide our approach to care planning. Using open-ended questions and Motivational Interviewing, the care coordinator and other ICT members **empower the member and their family/guardian to play a central role in the development of goals and identification of needs as they relate to their care plan.** In alignment with national best practices our Care Connection

team staff incorporate the core principles of member and family-centered thinking, planning, and most importantly, living, by:

- Recognizing the valuable role of all people in the member's circle of support
- Factoring in the impact of major life stages and changes on members and their family
- Collaborating to create a clear vision of a positive quality of life and develop an attainable path toward those goals
- Helping members and families increase their capacity to live a self-determined life in the community of their choice, while building social capital and economic stability
- Incorporating goals related to daily life and employment, community living, safety and security, healthy living, social and spirituality networks, and citizenship and advocacy
- Sustaining and/or making new connections with the community, and by linking them to innovative goods and services available both internal and external to the formal support system

Jackson is 16 years old and struggled with independent living skills, socialization skills, and anger. He often chose to stay home rather than going out into the community. He experienced panic attacks and became physically threatening when feeling anxious. His mother was very supportive of Jackson but is legally blind and had difficulty helping him due to her condition. Jackson's Tier 3 Aetna CSED care coordinator connected Jackson with a Behavioral Peer Support Specialist at WVU, to help him with transitions, independent living skills, and coping skills. His CSED team helped him apply for and get accepted to the Division of Rehabilitation Services and he begins job shadowing next month. The team also connected him to the Regional Transition Navigator program which provides transportation to volunteer opportunities. Jackson has been given increasing responsibility in catering services within this volunteer program. His mother said Jackson is enjoying his new experiences, socializing with others, and his new interest in baking. She says she was impressed that the Regional Transition Navigator Program is not only helping her son learn skills to encourage independence, but is also allowing him to have a positive outlook on his future.

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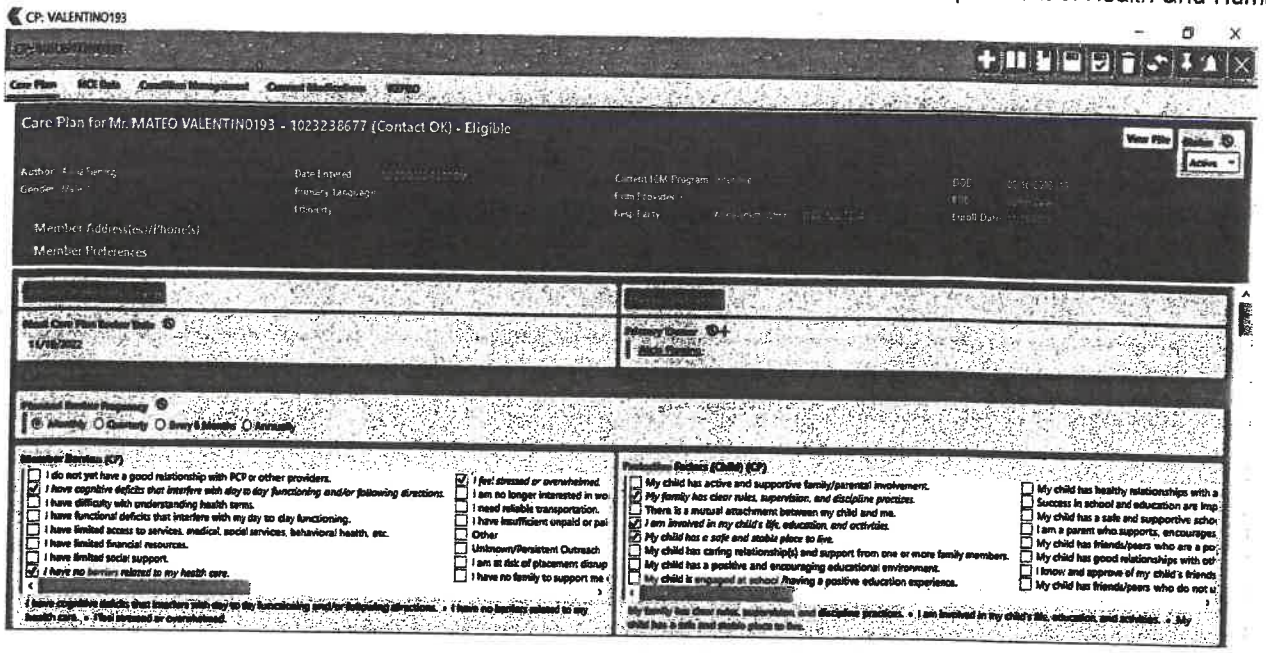
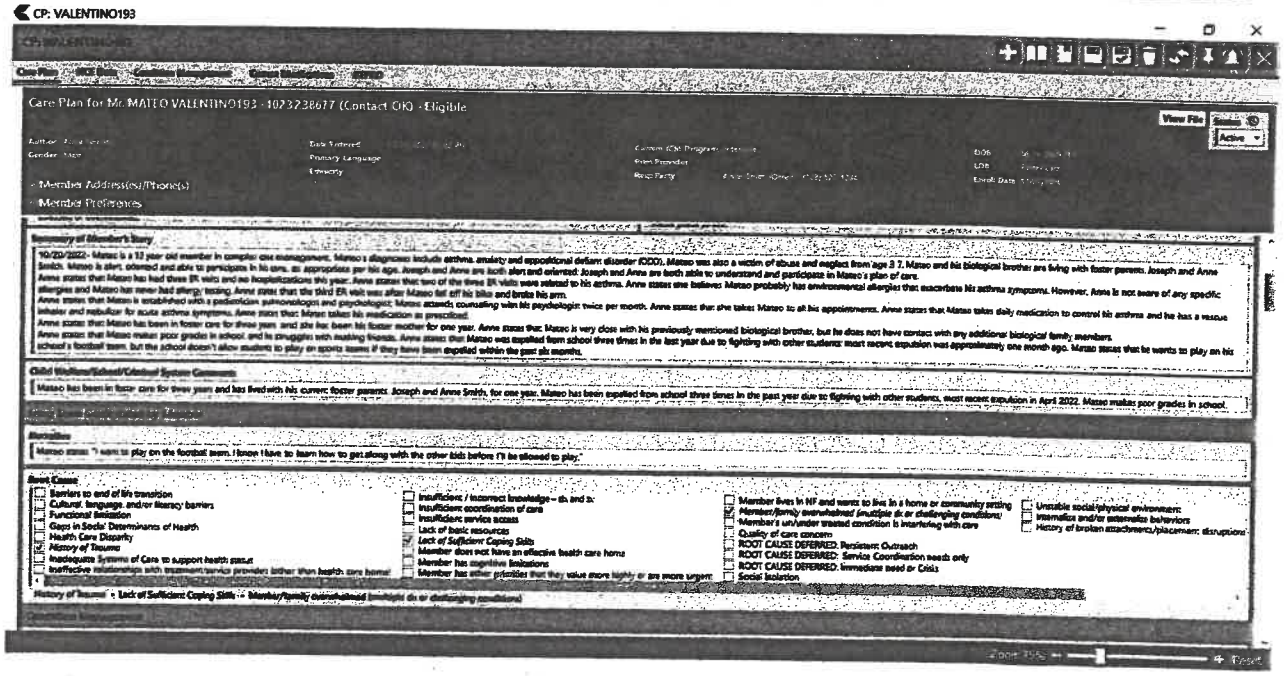
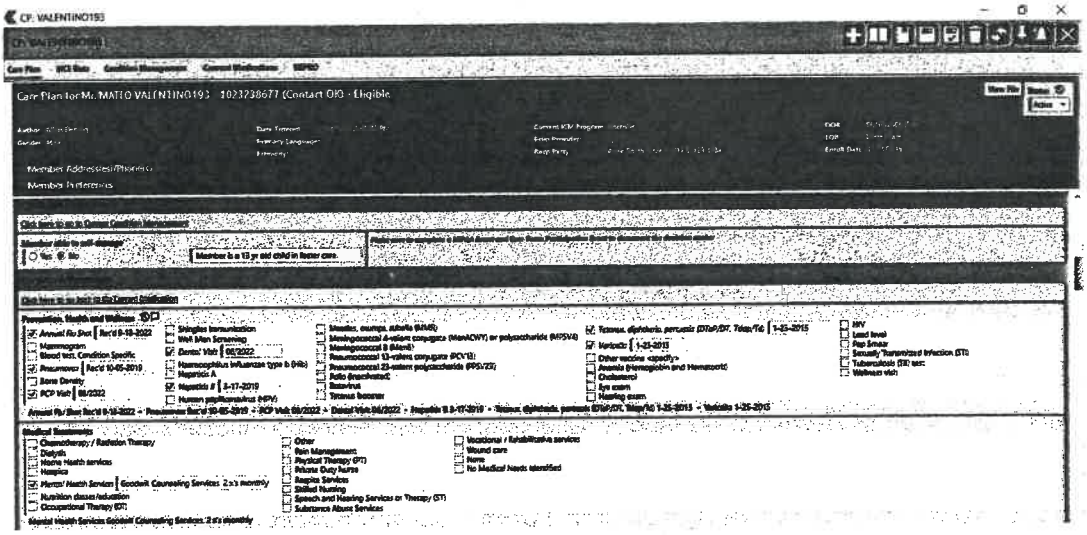
[CM11, CM24] **We document goals, objectives, services, and interventions identified by the member/family/guardian and ICT in the care plan.** Identified service needs may include primary services, specialty services, ancillary services, community, and social supports to address SDoH, SNS, and/or carved-out services like pharmacy NEMT. The initial screening and comprehensive assessments are the foundation against which the ICT verifies that the care plan addresses the member's needs. Interventions outlined in the care plan target special health care needs (such as obtaining DME for a child with diabetes or arranging for SUD services for youth who are using substances). **The final care plan must be agreed upon by the member and their family/guardian/caregiver(s).** Through the care planning process, **our care coordinators ensure collaboration with health and social services providers to verify services identified in the care plan are being delivered and attended by the member.**

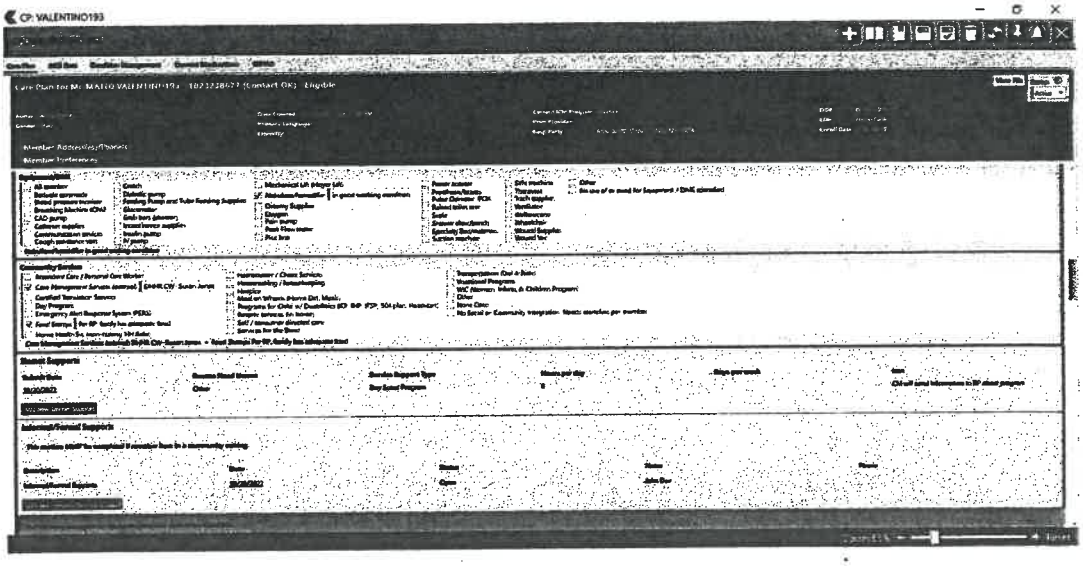
The provided screenshots below are of sample care plan (does not include the member's actual name/identifying information) [CM24].

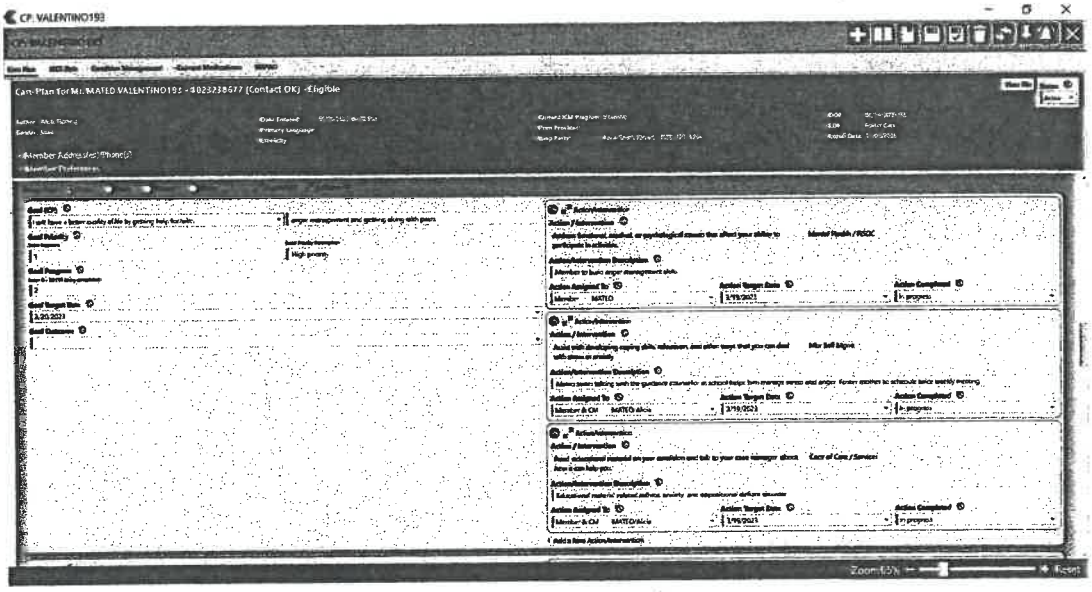

CP: VALENTINO193
Care Plan for Mr. MATEO VALENTINO193 - 1023238677 (Contact OK) - Eligible
Member Address(es)/Phone(s)
Member Preferences

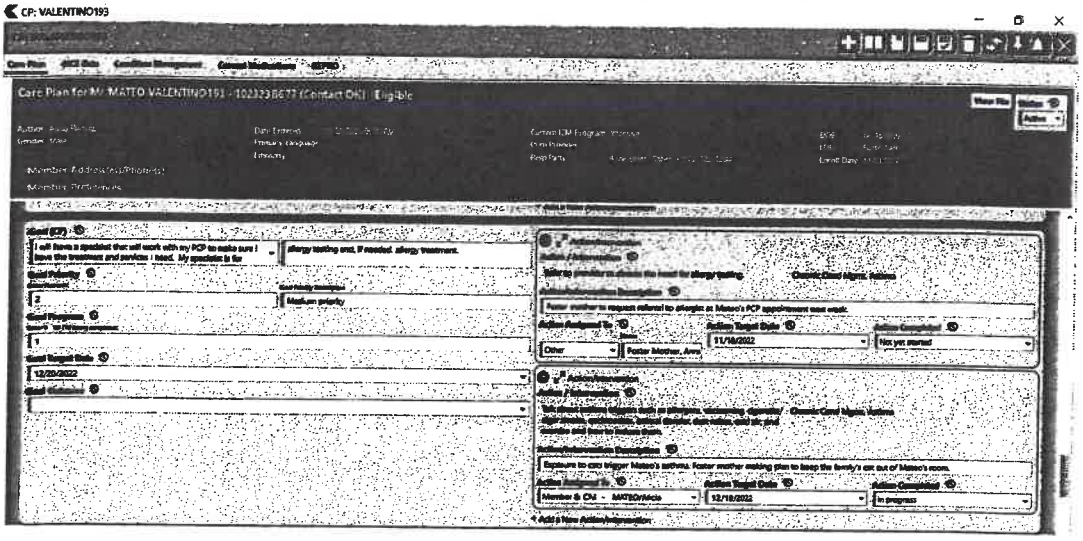

CP: VALENTINO193
Care Plan for Mr. MATEO VALENTINO193 - 1023238677 (Contact OK) - Eligible
Member Address(es)/Phone(s)
Member Preferences

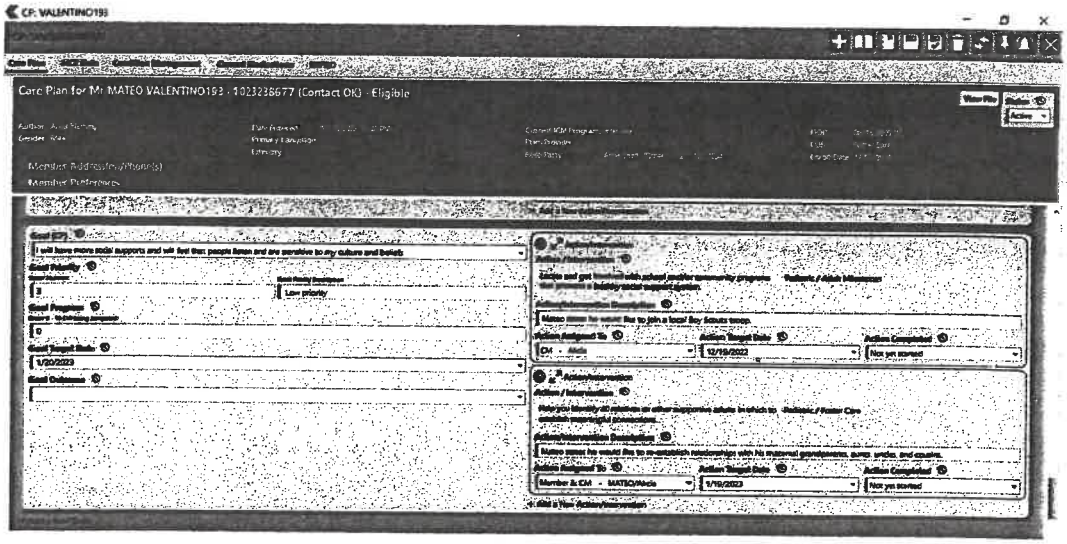
aetna

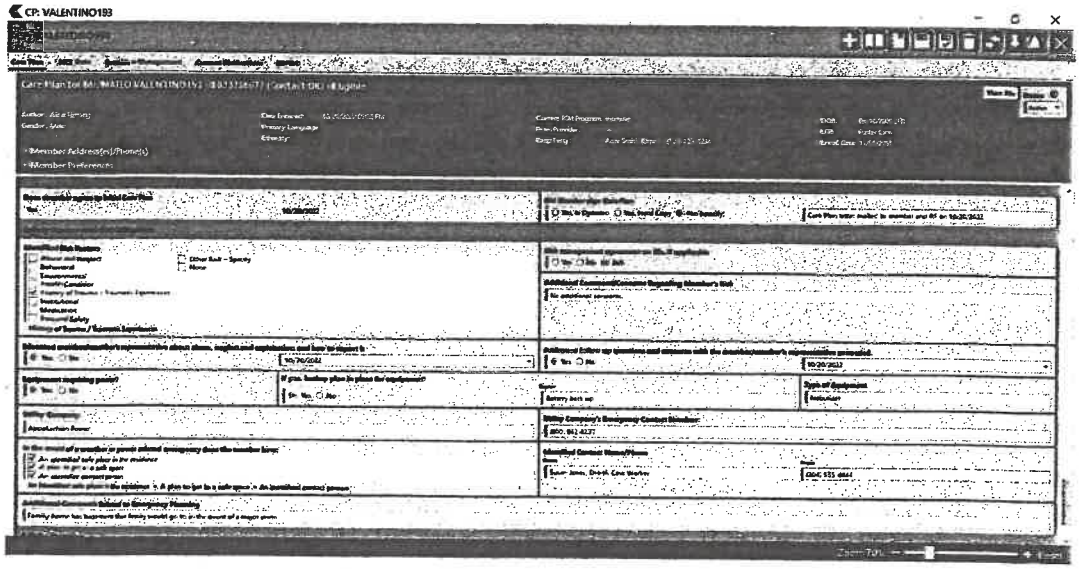

CP: VALENTINO193
Care Plan for Mr. MATEO VALENTINO193 - 1023238677 (Contact OK) - Eligible

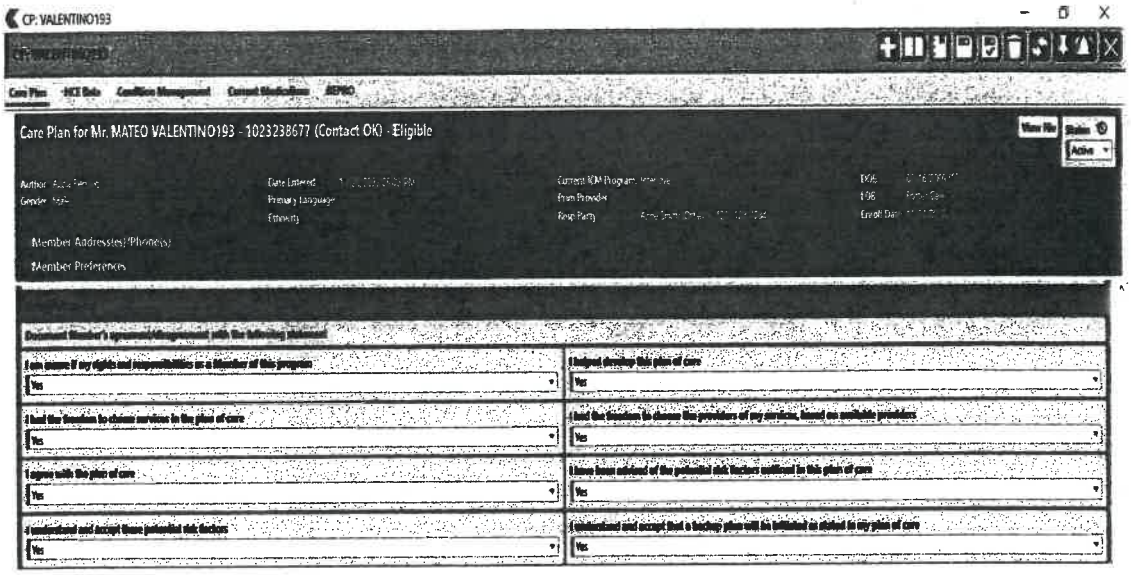

CP: VALENTINO193

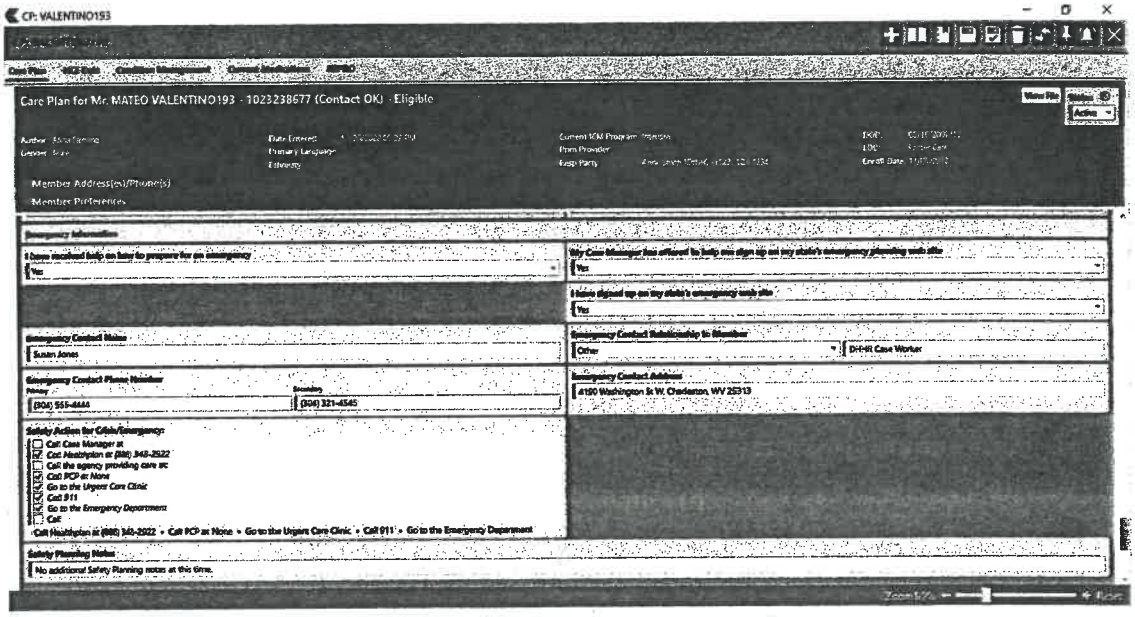

CP: VALENTINO193

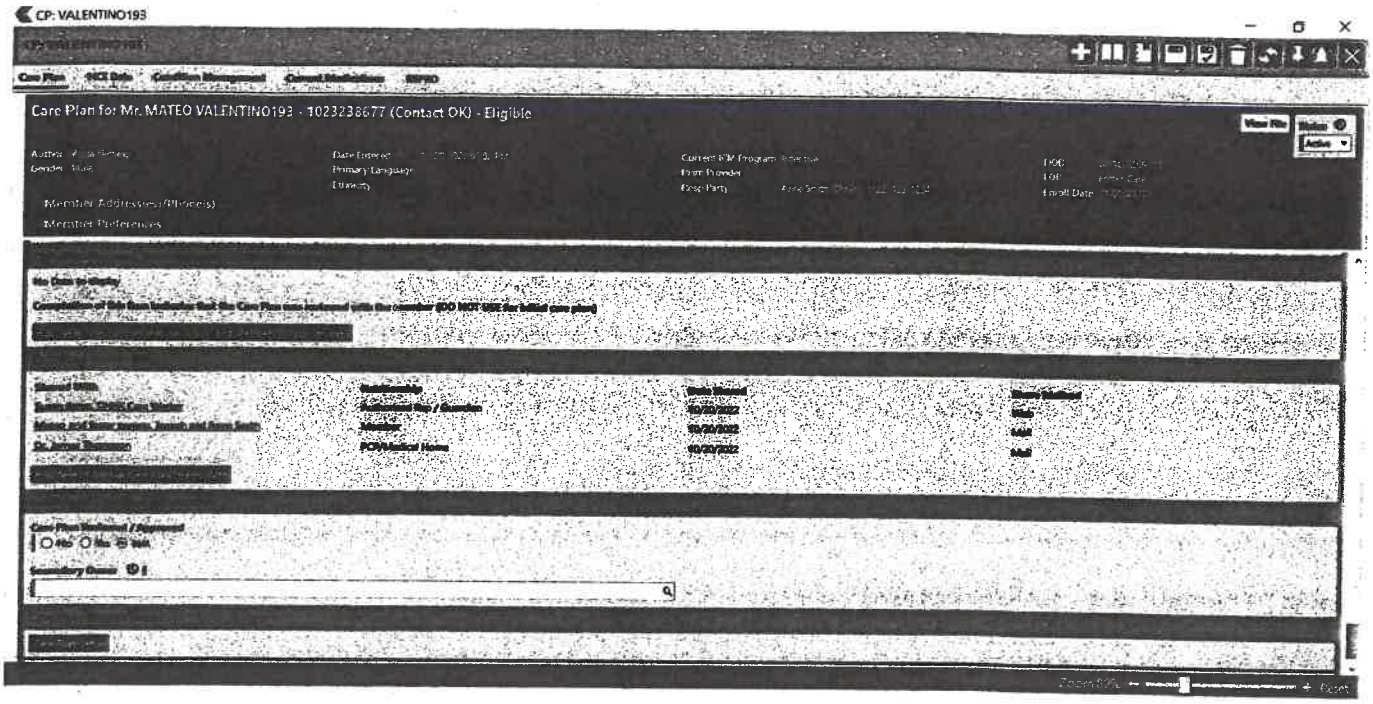

CP: VALENTINO193
Care Plan for Mr MATTO VALENTINO193 - 1023238677 (Contact OK) - Eligible


CP: VALENTINO193
Care Plan for Mr MATEO VALENTINO193 - 1023238677 (Contact OK) - Eligible


CP: VALENTINO193


CP: VALENTINO193
Care Plan for Mr. MATEO VALENTINO193 - 1023238677 (Contact OK) - Eligible
Active
Member Address(es)/Phone(s)
Member Preferences
I am aware of my rights and responsibilities as a Member of this program
Yes
I helped develop this plan of care
Yes
I had the freedom to choose services in the plan of care
Yes
I had the freedom to choose the providers of my services, based on available providers
Yes
I agree with the plan of care
Yes
I have been advised of the potential risk factors outlined in this plan of care
Yes
I understand and accept these potential risk factors
Yes
I understand and accept that a backup plan will be initiated as stated in my plan of care
Yes


CP: VALENTINO193
Care Plan for Mr. MATEO VALENTINO193 - 1023238677 (Contact OK) - Eligible
Active
Member Address(es)/Phone(s)
Member Preferences
Emergency Information
I have received help on how to prepare for an emergency
Yes
My Case Manager has offered to help me sign up on my state's emergency planning web site
Yes
I have signed up on my state's emergency web site
Yes
Emergency Contact Name
Susan Jones
Emergency Contact Relationship to Member
Other
DHHR Case Worker
Emergency Contact Phone Number
Primary
(304) 555-4444
Secondary
(304) 321-4545
Emergency Contact Address
4100 Washington St W, Charleston, WV 25313
Safety Action for Crisis/Emergency:
Call Case Manager at
Call Healthplan at (888) 340-2522
Call the agency providing care at:
Call PCP at: None
Go to the Urgent Care Clinic
Call 911
Go to the Emergency Department
Call
Call Healthplan at (888) 340-2522 • Call PCP at None • Go to the Urgent Care Clinic • Call 911 • Go to the Emergency Department
Safety Planning Notes
No additional Safety Planning notes at this time.




In addition to ICT care planning, we conduct **internal case rounds** for our foster care members in which we discuss between one and six members in twice monthly meetings. Case rounds provide a forum for the ICT, utilization management staff, Care Connection teams, pharmacy staff, and clinical leaders including medical directors **to discuss members with complex needs and collaborate on ways to better assist them.** Community health workers, CAT specialists, and peer support staff participate in the rounds and use their personal experiences to provide insight into social, recovery, and cultural factors that impact care. Clinical leaders collaborate with providers to enhance care for members through rounds. After review, the ICT works with the member and their PCP to **identify the root causes for gaps in care or barriers to meeting the member's needs** and develop care plan strategies to address those causes.

## Routine ongoing care coordination [CM01, CM02, CM03, CM05, CM07, CM11, CM16, CM22, CM24, CM26]

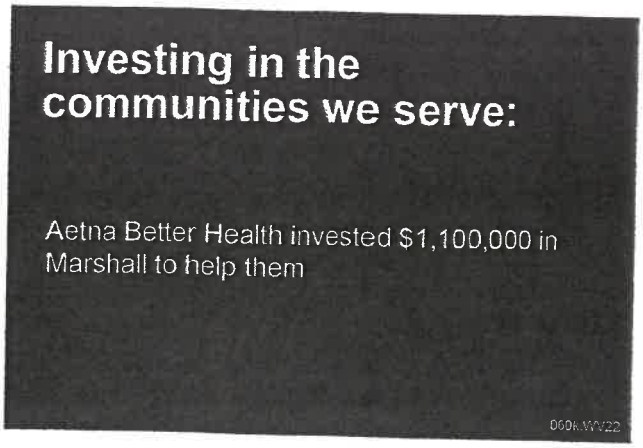
| | |
|---|---|
| CM01 | The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated Vendor care plan for all children. Additionally, the Vendor should identify individuals with complex or serious medical conditions, including, but not limited to, children with a serious emotional disorder (CSED), on an ongoing basis and track members with high physical and/or behavioral health needs to assure continuity of care.<br>The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.<br>Information on the WV CSEDW can be found at the following link:<br>dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx |
| CM02 | The Vendor should share all information required for continuity of care with the member and their family or caregiver(s).<br>The Vendor should describe how it will meet this specification, including, but not limited to, communication paths, methods, and/or frequency. |
| CM03 | The Vendor should evaluate and report member progress in meeting goals identified in the Vendor care plan to BSS and directly to the child/youth's case worker, attorney representing the child, Multidisciplinary Treatment Team (MDT) and other advocates as appropriate.<br>The Vendor should describe how it will meet this specification. |
| CM05 | The Vendor should collaborate with the Agency's pharmacy program to help provide coordinated care for the member, including, but not limited to, those members accessing psychotropic medications, and to ensure that all |

| | |
|---|---|
| | needed medications are available to the member after leaving an inpatient facility or changing levels of care for populations eligible for medical services. The Vendor should describe its drug utilization review process and criteria to include all members prescribed psychotropic medications. The State will supply the Vendor with pharmacy data. The Vendor should describe how it will meet this specification. |
| CM07 | The Vendor should monitor members' physical and/or behavioral health needs and respond to changes in acuity over time, at the intervals determined for the populations eligible for medical services. Risk Levels based on acuity are outlined in Appendix 3: Service Provider Agreement.<br>The Vendor should describe how it will meet this specification.<br>The Vendor should:<br>1) Describe its protocol for assigning members.<br>2) Describe its proposed clinical, social, or other criteria.<br>3) Provide the expected time frame for care coordinator assignment to the identified member. |
| CM11 | The Vendor should incorporate data about social determinants of health, as defined by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC) into its care coordination services.<br>The Vendor should describe how it will meet this specification |
| CM16 | The Vendor should identify opportunities on an ongoing basis for activities or linkages with West Virginia (WV) Children with Special Health Care Needs (CSHCN) (Title V) program clinics, providers, or other professionals.<br>The Vendor should describe how it will meet this specification. This description should describe an understanding of the WV CSHCN program and the interaction of the Foster Care Liaison. |
| CM22 | The Vendor should establish and implement guidelines for how often the care coordinators will contact members after initial care coordination contact, based on the member's acuity level. The Vendor should include guidelines for care coordinators to have face-to-face contact with their assigned members, including, but not limited to, when requested by an Agency worker. Outreach frequency should correspond to acuity. Risk Levels based on acuity are outlined in Appendix 3: Service Provider Agreement.<br>The Vendor should describe its approach to care managers' face-to-face contact with assigned members, including, but not limited to:<br>1) Frequency<br>2) Circumstances resulting in a need for face-to-face contact<br>3) Goal of face-to-face contact at this frequency and/or in these circumstances |
| CM24 | The Vendor should identify members in need of a Vendor care plan and develop, update, and use clinically appropriate Vendor care plans that address coordination of primary services, specialty services, ancillary services, community and social supports, and/or carved-out services for members identified as having special healthcare needs, based on that member's needs.<br>1) The Vendor should describe the process and/or mechanisms for identifying members in need of such a plan.<br>2) The Vendor should describe in detail the process for developing, updating, and using these Vendor care plans.<br>3) The Vendor should provide a sample Vendor care plan. |
| CM26 | The Vendor should monitor utilization and coordinate services for carved-out services such as pharmacy and non-emergency transportation (NEMT).<br>The Agency has no plans to carve pharmacy benefits in at this time. However, if pharmacy benefits were carved in at a future date, the Vendor would be responsible for utilization management of pharmacy benefits.<br>The Vendor should provide the policies and procedures for how it will monitor and coordinate care for carved-out services. The Vendor should describe any data that would be needed from the Agency to facilitate this monitoring and coordination.<br>The Vendor should provide a general description of its ability to meet this specification, if pharmacy benefits are carved in at a future date. |

Following initial assessments and the creation of the individual's care plan, Care Connection teams continue to conduct **routine ongoing reassessment, care plan updates, and care coordination** to aid members in achieving their goals. Here we will also describe ongoing care coordination approaches specifically related to:

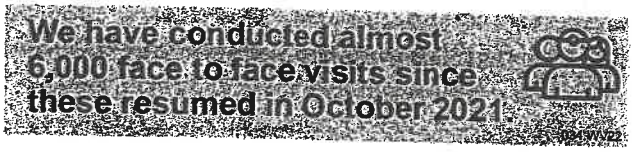
- Health and community/social services
- Carved-out services (pharmacy and NEMT)
- Title V services

## Ongoing assessment, care planning, and coordination of care for all members [CM01, CM02, CM03, CM07, CM11, CM22, CM24]




Our electronic care management system tracks member progress towards care plan goals. As care coordination continues following creation of the initial care plan, **the member, their family/guardian, care coordinator, and the ICT meet and review the member's progress (or lack of progress) towards the member's care plan goals** in response to receipt of services identified in the care plan. [CM01]. During this review, we complete an **Interval Assessment** with members, including those with high physical, behavioral, or special health needs, to determine whether their needs have changed. We run our **predictive risk stratification analysis on all members on a monthly basis**, which also alerts us to changes. [CM07]

[CM22, CM24] Care Connection teams and the assigned care coordinator facilitate the completion of **updated member assessments and care plans** in collaboration with the member/family/guardian and ICT. We complete the **HRA screening annually** (at minimum) for all members assigned to Tier 1 care management. We conduct a **comprehensive reassessment** for members in Tier 2 or 3 care management that includes other specialized assessments or reassessments annually or more frequently if clinically indicated. We **update care plans** monthly for members in Tier 2 or 3 care management (and more frequently as significant life changes such as home removal, placement changes, or admission to an inpatient facility occur). **We outreach members in Tier 1 quarterly to repeat the Pediatric Risk Screener** to evaluate need for a care plan update or a higher level of care management. We update care plans in our care management system, if there is a change in the member's health conditions, the need for socially necessary services, or a significant change in SDoH [CM11]. Care coordinators set follow up tasks in our electronic care management system to notify them when reassessment and care plan updates are due.




In the description of tiered care management services/interventions associated with each tier, we have also outlined **minimum requirements regarding other types and frequency of ongoing care coordinator contact with members**. [CM22] We conduct **face to face interactions** via in person ICT care plan update meetings or home visits as needed to provide ongoing support, ad hoc assessment, or connection to additional services when a member's medications or life or health circumstances change significantly. Face to face visits help maintain and strengthen our relationship with the member and their guardian/circle of support.

At times of reassessment and care plan updates, **the member and their ICT/providers may identify that the member may be better served in a higher or lower level of care coordination intensity.** When members move between Tier 2 and Tier 3, they remain assigned to the same care coordinator, but we adjust the intensity and frequency of intervention to the new tier-based requirements [CM07]. A care management associate reassigns members who move from Tier 2 or Tier 3 down to Tier 1 to receive ongoing support and collaboration from the previous care coordinator to ensure continuation of the care that led to the improvements.

**We share information regarding member progress towards goals with BSS and directly with the child/youth's case worker, attorney representing the child, MDT, and other advocates as appropriate [CM03] in care planning meetings.** We document and store current and prior assessments and care plans in real time as the care coordinator documents in the electronic care coordination system which feeds to FamilyConnect. **Members/families/guardians and BSS case workers, who are members of the care team, can access this information in FamilyConnect** to stay apprised of goals and progress towards those goals. [CM03] Providers may access this information through the provider portal, but care coordinators can also mail or securely email assessments and care plans to their providers upon request and if permitted by the member/guardian [CM02] for continuity of care purposes.

As ongoing care coordination continues, if the care coordinator identifies a provider member of the ICT that is not contributing to collaborative activities, they may outreach the provider liaison assigned to the provider for assistance in getting the provider to respond or step in. If the provider does not respond to provider liaison involvement, additional steps (such as issuing a quality-of-care concern, if applicable) may be taken.

## Coordination of Health and Community / Social Services [CM24]

In addition to ongoing assessment and care plan updating, the care coordinator is responsible to provide members and their families assistance in scheduling ongoing primary, specialty, and ancillary health care appointments, if needed. **Care coordinators assist with cross-system navigation to ensure every young person receives and attends needed health care appointments, socially necessary services, and support identified in the care plan** [CM24]. Care Connection team staff enter task reminders in our electronic care coordination system to track required appointments that are coming due, as well as reminders regarding scheduled appointment dates. Our Quality shares information with the Care Connection team about members who have not received required HEDIS visits. Care Connection team staff may contact the member (or their guardian as applicable) following missed appointments to assist in rescheduling and may outreach providers and PCPs for assistance in resolving gaps in care.




**We coordinate all aspects of person and family-centered care, including the required HealthCheck screenings, required health supervision visits, and 90-day follow-up visits for children in foster care in accordance with frequency expectations given by the Department;** primary care via a medical and dental home, care provided at school-based health centers; specialty provider services, respite for caregivers, medication management, management of chronic conditions, and peer support services; and programs to meet members' social determinant needs. This routine coordination occurs during telephonic contacts with the member and their family/guardian or at ICT meetings or other face to face contacts with the member. During these contact points, the care coordinator reviews the care plan and talks with the member and their family/guardian regarding they whether they are attending services outlined in the care plan, as well as whether they are experiencing any barriers to receiving services or medications. For example, **if they are facing barriers due childcare or transportation needs, the care coordinator can intervene to assist on their behalf in the resolution of barriers.** We also work with the West Virginia Primary Care Association to ensure

that PCPs understand the importance of informing the Care Connection team when a member has missed an appointment.

**Social Services to address SDoH:** Throughout the care planning process and ongoing care coordination efforts for all members (including those with special health care needs), the care coordinator and ICT identify community resources and social services that may address the SDoH needs, or goals outlined in the member's care plan. These needs are re-evaluated at the reassessment and care plan update intervals described earlier in this response. When the ICT identifies a particular community resource or social service is needed, we establish the date by which the service must be obtained in the care plan, depending on the urgency for the individual member. **The care coordinator uses our Community Resource Directory and leverages our relationships with community partners to link members and their families to the appropriate social services in their region.** For members with urgent social service needs, we follow up within 24 hours to ensure they were able to access the needed service. For non-urgent needs we follow up within 30 days. Examples of the types of social services we refer members to include:

- Connection to the "Working for Success" program which offers technical skills training, employment services, and other SDoH supports through our partnership with JobCorps
- Education and assistance to obtain SNAP and WIC benefits to address food insecurity, connection to food pantries

**We may invite representatives of organizations offering community resources or social services to ICT meetings, with permission of the member and their guardian/caregiver(s) as needed.**

**We have well-established statewide and regional relationships with West Virginia community resources and social service agencies** such as the following: Right From the Start, Birth to Three, the Children with Special Healthcare Needs program, BSS, Kepro, Perinatal Partnership, Safe at Home, American Cancer Society, Youth Advocate Program, Our Babies Safe and Sound, Help Me Grow West Virginia, Helping Appalachian Children and Infants, Tobacco Free Families Advisory Council, March of Dimes, Mountain State Healthy Family, Circle of Parent, PROACT, WIC, and Mountains of Hope.

> "Camp Appalachia serves vulnerable youth ages 5-17 in the areas of dynamic character and leadership development, spiritual growth, substance abuse prevention , and social educational advancement. Our programs include overnight camp, day camp, wilderness, survival camp, family camp, and weekend "Dad skills" camp. We are able to provide these services free of charge for kids who have a parent incarcerated, kids who are or have been in the foster care system, and kids from low-income or marginalized areas because of the help and funding from Aetna Better Health® of West Virginia (Aetna Better Health). As an example, Aetna provided funding for a camper who had been abused in the past. He did not have many supportive adults in his life. On his first day at camp, he was unable to stay with his group. He was violent, had trouble communicating, and even hid under the table during meal times for fear of someone stealing his food. By the end of the summer, he was thriving, getting leadership awards, and even winning a lipsync competition. The staff and outdoor atmosphere were able to break through to this camper and he had a very successful summer. One that none of us will soon forget. We are blessed to work with Aetna Better Health of West Virginia, and we look forward to continuing this amazing partnership in the future."
>
> Jared Davis,
> Executive Director, Camp Appalachia

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## Coordination Of Carved-Out Services: Pharmacy And NEMT [CM05, CM26]

We have experience and well-established protocols to monitor and coordinate care of caved-out-services such as pharmacy and NEMT. To enhance our capability to coordinate carved-out services, we **request DHHR provide all pharmacy and NEMT utilization and high utilizer data for incorporation in care planning with members and providers.**

**Coordinating pharmacy services and monitoring adherence:** Care coordinators and the Care Connection team play a critical role in working with members, families/guardians, the ICT, and the Department's pharmacy program to ensure coordination of pharmacy needs. This includes verification that medication management services are occurring, and the ICT has secured authorizations (when applicable) to ensure members have access to all medications prescribed by their physicians, including psychotropic medications. The care coordinator completes **medication reconciliation** with the member by accessing the state's preferred drug list. They can seek assistance from our pharmacy director during this process, who may then outreach pharmacies or prescribers if needed. The care coordinator can assist the member with medication questions, issues, or concerns by contacting Gainwell Technology regarding any prescription questions. For providers with authorization questions, the care coordinator can contact Rational Drug Therapy (RDTP). Care coordinators evaluate **condition-specific medication adherence** during interactions with members diagnosed with targeted conditions such as diabetes or asthma to identify opportunities for improved adherence. We discuss findings with the member/family/guardian and ICT and document strategies to improve adherence in the care plan.

**Monitoring pharmacy utilization:** We designed our **Children's Health Administration of Medications Monitoring Program (CHAMMP)** to conduct Drug Utilization Review (DUR) of psychotropic medications. We include members in our CHAMMP program if they meet one of the following criteria:

- Members under age six with prescription(s) for psychotropic medication(s)
- Members aged six to 12 with prescription(s) for atypical antipsychotic, antidepressant, or mood stabilizer medication
- Members with psychotropic medications and no documented behavioral health service visits
- Members under the age of 18 with two or more psychotropic medications
- Members filling prescriptions for psychotropic medications for three or more months without a behavioral health visit




During the initial assessment phase and ongoing care planning process, the chief medical officer (CMO)/medical director and the clinical pharmacy advisor review pharmacy utilization data to identify members who meet CHAMMP criteria. Our care coordinators outreach these members to conduct medication review and discuss safety concerns. They also intervene and communicate with prescribing practitioners on identified prescribed medication concerns. For example, post-traumatic stress disorder is often misdiagnosed in children resulting in inappropriate prescribing of psychotropic medication. As described earlier in this response, the TSQ is administered as part of the initial screening process and is repeated in 30 days for members with behavioral health diagnosis. Members with a behavioral health diagnosis and a TSQ score of 6 or greater at the 30-day rescreening are referred to their behavioral health provider to assess for post-traumatic stress disorder to ensure the member is appropriately diagnosed and treated.

Problems identified through DUR processes may lead to medical peer-to-peer consultation, collaboration with the Department's pharmacy program, a quality-of-care referral, or other actions, depending on the situation and initiate follow up as needed.

**Ensuring members have the medications they need when discharging from inpatient facilities, changing levels of care, or returning from out-of-state:** Our **transitional care management policies and procedures** promote close coordination of all aspects of members' care as they discharge from inpatient hospitals or residential placements to the community, change levels of care, and/or return from an out-of-state placement. This includes coordinating ahead of time to **ensure that bridge medications and/or medication approvals are in place,** where required, prior to the transitioning event.

In situations where BMS notification indicates release of a member from an out-of-state facility, and is back in state, they place the member on the "bypass table" for 6 months to allow continued payment of out-of-network/state prescriptions until the member/family/guardian and ICT find an in-network prescriber. Once members are receiving prescriptions from in-state pharmacies and enrolled prescribers, they remove the member from the bypass list. However, in situations where BMS may not be certain regarding whether a member has transitioned back home, our Care Connection team works with the out-of-state PRTF/placement to coordinate a smooth transition. We then notify BMS of the member's status to ensure they are added to the bypass list.

Additionally, members who are returning home from a placement may have been started on (or are stable on) medications from the facility that are non-preferred on the state preferred drug list. When our Care Connection team is aware of those situations, the care coordinator informs our pharmacy director who intervenes to resolve the issue. The care coordinator works with the facility/prescriber to call RDTP and confirm the current therapy the member is on to allow grandfathering of the current non-preferred therapy.

**Ability to coordinate carved-in pharmacy services in the future: Aetna has previously coordinated carved-in pharmacy services in the state of West Virginia.** We support a future return to carved-in pharmacy services and can implement such a change in a seamless manner. In our previous management of carved-in pharmacy services we directly resolved barriers to members' access to medications rather than contacting RDTP for assistance. We also employed our lock-in program in clinically appropriate circumstances.

**Monitoring and coordinating NEMT:** As a critical SDoH, we evaluate members' access to reliable transportation during our initial and ongoing assessment and care planning processes to make sure members can attend all health services identified in the care plan. We help members schedule transportation ahead of time, interfacing with the transportation vendor as needed should obstacles arise. The care coordinator monitors referrals to transportation services and resources and verifies whether the member received the service.

## Activities with West Virginia Title V Program clinics, providers, and professionals [CM16]

We conduct collaborative activities with family-centered, community-based, systems of coordinated care for children with special health care needs, including early intervention and screening, linkage with parent support groups and forums, and adolescent pregnancy prevention programs. **Our CAT administrators work with the Office of Maternal, Child and Family Health (OMCFH)** to improve members' sense of safety, the member experience and access to services, and to reduce barriers to achieving health goals. Currently, we attend a monthly meeting with OMCFH to discuss strategies to remove or mitigate service barriers for individual children with special health care needs. As described in greater detail later in this response, we offer **specialized care management for babies with NAS** and follow them closely for their 18 months of life. As another example of linkage with the Title V

program, Care Connection teams work with schools and school districts to ensure children transitioning (from age 0 to 3 population) to the school system have IEPs where appropriate. Our adult and child CAT administrators will work with the OMCFH to track success and address any barriers.

**We attend monthly meetings with the Foster Care Liaison** (Ombudsman) to discuss systemic coordination opportunities. The Liaison also provides training to our care coordination staff regarding Title V program services and interfaces with Care Connection team staff to help resolve specific member issues.

## Special care coordination circumstances [CM04, CM09, CM 25, CM27]

| | |
|---|---|
| CM04 | The Vendor should develop a process to engage the child/youth's caseworker, attorney representing the child, and other advocates as appropriate in the care planning process.<br>The Vendor should describe how it will meet this specification. |
| CM09 | The Vendor should assign an initial risk stratification tier within the first 30 days of enrollment. For those enrollees who require Intensive Care Management (ICM) the Vendor should determine the composition of the ICM team and develop a care plan specific to each case for members with one or more chronic conditions.<br>The Vendor should also review all treatment plans for members placed in a Residential Mental Health Treatment Facility (RMHTF) or Psychiatric Residential Treatment Facility (PRTF) at a minimum of monthly to ensure appropriate treatment and participate in meetings with the RMHTF or PRTF as requested by the Agency. The Vendor should also complete a 90-day review of the treatment plan to assess appropriateness of a discharge to a less restrictive setting.<br>The Vendor should describe how it will identify children/youth who exceed Level 3 needs and any children/youth who require a more intensive care management strategy to address complex cases, high priorities, children dually involved in the child welfare and juvenile justice systems, and/or if BSS determines the need. |
| CM 25 | Upon notification of the occurrence of a crisis situation, the Vendor should provide immediate assessment and care coordination interventions for the child.<br>The Vendor should describe how it will coordinate and provide interventions in crisis situations. |
| CM27 | The Vendor should develop a process to identify and manage the care of members that are transferring from juvenile justice facilities to foster care placements.<br>The Vendor should describe how it will meet this specification. |

At times, individual circumstances require more intensive or specialized coordination activity. **When members face possible home removal, placement changes, are in RMHTF or PRTF, require specialty care coordination for NAS, or are experiencing a crisis, our Care Connection team takes responsive action to mitigate disruption and ensure seamless coordination.**

## Home removals and placement changes [CM04, CM27]

**Urgent disruptions:** During times of imminent and significant life changes (including first removal, placement changes, aging out, homelessness, loss of all parents), care coordinators foster smooth member transitions through increased communication with caseworkers, families/guardians, and the member's attorney, if applicable, and schedule ad hoc care plan reviews. We reevaluate whether the member should receive additional services or care coordination at a higher level than their current tier. When the member/family/guardian and ICT determines that the member needs a higher level of care management or health care services, the care coordinator takes immediately action to implement and coordinate these changes. **When these life events occur, we recognize members may experience additional trauma, so we take special care to offer close and supportive coordination with the member, guardian/family and BSS workers serve to minimize trauma** [CM04].

**Preventing disruption:** It is standard practice for the care coordinator and Care Connection team, through ongoing contact and reassessment with the member, to **monitor for any stressors or changes in the home which suggest instability.** In alignment with our Safe at Home model and Family Finding approach, Care Connection teams also increase coordination efforts to minimize the

need for removals or placement changes when there are signs of impending change. We **intensify coordination and update care plans** to increase wraparound services and socially necessary services to address emerging needs. We may also escalate our efforts through increased frequency of face to face or telephonic contacts, reviewing the case in rounds or through **special reviews with members of the MDT**, consulting with our behavioral health medical director, or adding new experts to the ICT (with member/guardian permission) for a limited time to troubleshoot and identify protective measures, interventions, and services that can prevent home removal. **We completed 116 reviews in 2021 and over 200 reviews from January 1, 2022, through October 2022 in collaboration with MDTs.**

We may consider offering non-covered services on a case-by-case basis if it may help prevent placement disruptions. We are aware that removal rates are often based on neglect due to parental substance use (particularly opioids). In these cases, we collaborate to identify possible kinship placement. Simultaneously, we collaborate closely with parents' health care providers and health care coordinators (as permitted by the parents) to ensure they are getting SUD and mental health services, in addition to services to address chronic medical conditions or SDoH that place the child's safe maintenance at home in jeopardy.

We also coordinate referrals to **Family Assessment and Stabilization Team (FAST)** intervention services for members, typically between nine and 17 years of age, who are in crisis and at risk of imminent admission to a hospital psychiatric unit or are homeless because of severe family conflict or ejection from a placement. They tend to have no family connection and frequent changes in caregivers. The focus of the FAST intervention is on safety, stabilization, well-being, and permanency. The length of the intervention averages 90 days. When a dependent child is referred for a FAST intervention, the referent often states with certainty that the child has no family, either extended or immediate. For dependent children separated from family and served in FAST, the single most identified variable contributing to positive outcomes involves meaningful connections with family members. If the child's biological (or adoptive) parents cannot be a resource, our staff begin an extensive search for family, using the Family Finding model to broaden the search to all relatives of specified degree and paying equal attention to the often-overlooked paternal side of the family.

Managing care for youth transferring from juvenile justice facilities to foster care placements [CM27]: We receive a list of members who are about to transfer from juvenile justice facilities to foster care placement. Prior to the transition, our Care Connection team monitors their status through a tracking database, assigns a care coordinator, and begins planning for the transfer. The Judicial Liaison and our care coordinator work with BJS and BSS to determine appropriate services and supports that would best suit the youth and foster family and ensure that those services are in place. Services may include CSED, Safe at Home, therapy, medication management, etc. The care coordinator continues to assist the member and their family/guardian once in a foster home. We connect them to services and supports that can assist the foster home in maintaining the youth's behaviors, so they are able to receive treatment in the foster care setting.

## Reviewing treatment plans for members in RMHTF or PRTF planning [CM09]

We review treatment plans for members in RMHTF or PRTF monthly (plus a 90-day review) to assess progress towards goals and meet with facility staff to discuss discharge planning for a less restrictive level of care.

We also monitor CAFAS scores for members in RMHTF to help determine the appropriate level of care for members based on their functioning across critical life scales. The CAFAS utilizes multiple sources

of information provided by the youth, caregivers, case records and other informants. Descriptors are included in ratings of various life areas. Each area, or subgroup, is rated from severe, moderate, mild or no impairment. A score of 30 is assigned for each subgroup with one or more behaviors selected with the severe category. A score of 20 is assigned for one or more behaviors selected within the moderate impairment category. A score of 10 is assigned for one or more behaviors in the mild category. A score of 0 is assigned for behaviors selected within the minimal or no impairment category. Using this scoring process, a youth could have a total CAFAS score ranging from 0-240. This is the sum of the scores from each subgroup.

The guidance for interpreting CAFAS total scores is: 0 to 10 no noteworthy impairment; 20 to 40 treatments on an outpatient basis would likely be appropriate; 50 to 90 additional services beyond outpatient care may be needed; 100 to 130 more intensive care and sources of support beyond outpatient services are indicated; and 140 or more intensive treatment may be warranted.




**Using CAFAS information, we work with BerryDunn to assure placement of youth in the most appropriate level of care based on individual need and as indicated by the CAFAS scores**. We began by focusing on youth whose CAFAS scores are 50 or below in February of 2022, 50-90 in April, and 90-110 in October 2022. We developed a spreadsheet to include treatment planning, CANS assessment, and family information with Family Finding. We use the spreadsheet to **guide discharge planning and identify barriers to the discharge plan and any mitigation factors.** We send out a RMHTF tracking spreadsheet to BerryDunn by the 12th of the month or next business day. Once received, the BerryDunn analytics team analyzes the data and creates a monthly dashboard where information is broken down by various categories including but not limited to barriers to discharge planning by facility type, by length of stay, and by discharge characteristics. **We can then identify providers who need training in specific areas and youth whose CAFAS score is inconsistent with their current placement or level of care.**

## Care coordination for members with NAS

To address the critical health needs of babies with NAS and to foster their ability to remain with their mothers, we offer NAS care coordination. **For 2022 Q3, 81% of babies in this program were able to remain with their mothers.** We incorporate the following elements and activities in this program:

- The Care Connection team includes a peer support specialist who has successfully overcome their own SUD, can participate on the ICT, and offers sponsorship and support through telephonic and home visit contacts with the member and their guardian.
- We help locate treatment and offer support to maintain parental sobriety. We give members who complete the NAS program a cribette or baby carrier after delivery.
- We enroll babies affected by NAS in care management and follow them for up to 18 months. The care coordinator offers education, support, and tracks milestone development. We provide members a milestone development toy after graduation from the program.
- Care coordinators are onsite at MAT facilities in the central, southern, and western regions of state and can meet members face to face when they come in for treatment.

BSS had previously taken custody of her other children. Carolyn attended Medication Assisted Treatment (MAT) and was prescribed Subutex. For these reasons, BSS did not seek to take custody of her newborn. After she gave birth, we assigned her to a specialty care coordinator in our NAS program. She began receiving NAS treatment through Lily's Place and was admitted to Project Hope where she would stay until she felt comfortable with her MAT. Carolyn spoke often with her Aetna care coordinator to plan for her life after her eventual discharge from Project Hope. They discussed her potential living environment, barriers to recovery, and life with an infant alone, as the father of the baby was incarcerated. Carolyn established goals for herself was able to form a close bond with her new infant during visits. Her care coordinator educated her on symptoms of NAS that she should watch for that would need attention during the early days upon completion of care with Lily's Place. She was able to develop a routine and attend all well child and vaccine visits for her infant. Carolyn was also able to reestablish a mature relationship with her own mother. Carolyn has graduated from Project Hope, has moved back home with her mother, and is trying to find a place of her own. She is also looking for a job so that she is able to provide for and support her daughter. She continues to work toward her long-term goals and keeps her care coordinator updated on all new accomplishments.

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- Each Care Connection team region has an assigned SUD specialist and behavioral health specialists. These specialists are excellent sources of information regarding SUD services and can aid in connecting members to these services.

**Aetna and Drug Free Moms and Babies are piloting a program with BSS to provide early intervention** to mothers and babies affected by SUD. We provide the birth mother support and assistance with locating necessary treatment programs. The program seeks to maximize the parent-child relationship, reducing the number of infants placed in foster care and helps reunite mothers with their children when it is safe to do so. In 2021, there was a decrease in preterm births in this population from 19.4% to 12% (equal to the general WV population). In 2021, 74.9% of women entering the program showed illicit substances in their urine drug screens. By delivery, that number decreased to 35.8%. Cord blood testing at delivery revealed that 67% of these babies were negative for illicit substances. **74% of these babies were discharged with their mothers, avoiding entry into the foster system.**

## Managing crises [CM25]

Our Care Connection teams/care coordinators may learn that a member is in crisis based on direct interaction with the member/family/guardian or through other internal or external referrals. Upon

notification of the crisis, the care coordinator assesses the situation and connects the member and their family/guardian to urgent crisis, medical, or first responder assistance, if clinically appropriate. For less imminent crises, the care coordinator facilitates an ad hoc special review with the member/family/guardian and ICT to identify immediate needs and services to address the member's specific situation, whether the need is related to a behavioral health, housing, or other type of crisis. We coordinate member referrals to FAST in appropriate circumstances.

We also provide members in the Mountain Health Promise program with information in the member handbook and member portal regarding how to contact the 844HelpWV crisis line as needed. This crisis line can connect members to mobile crisis and respite services. We also discuss the availability of these services, and when they should be used, during the creation of members' care and safety plans. For members in the CSED waiver, our CSED CMs review and monitor all care plans to ensure compliance with required services and inclusion of a safety plan.

On a larger scale, we intend to implement a **Next Best Action** outreach campaign for members under adoption/legal guardianship that we have identified to be at greatest risk for future self-harm (e.g., have previously had suicide attempts or ideation, answered yes to having suicidal/self-harm thoughts in assessments with care management, historical inpatient/emergency department (ED) with depression or psychosis). Through supportive messaging and other educational outreach efforts, we aim to reduce self-harming behaviors.

## Patient-centered medical homes [CM06]

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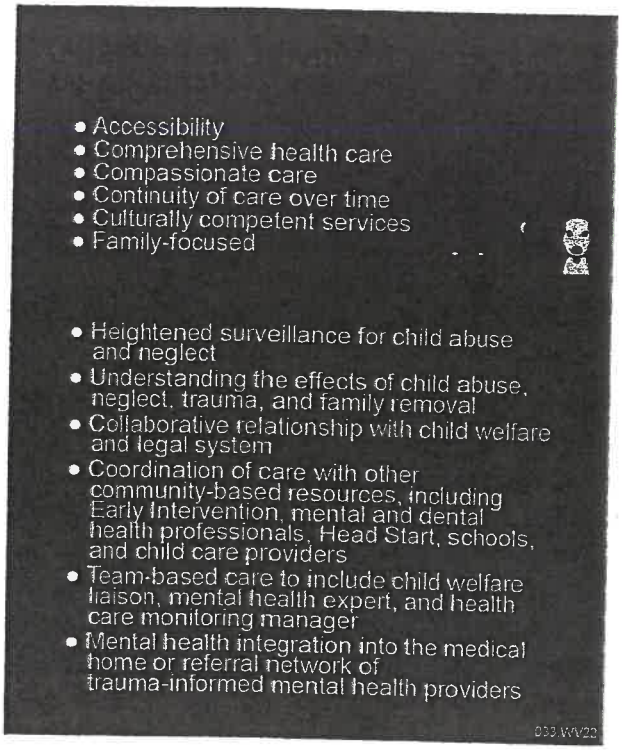
| CM06 | The Vendor should establish and maintain patient-centered medical homes for its members eligible for medical services in alignment with the American Academy of Pediatrics (AAP) guidelines outlined in the Health Care Issues for Children and Adolescents in Foster Care and Kinship Care technical report, including, but not limited to, the following:<br>• The application process for providers<br>• Assessment of whether foster care members can continue to receive healthcare in their medical home of origin, and if not, how best to establish and maintain new medical homes<br>• Communication with members and/or their caregivers/families, as appropriate, about patient-centered medical homes for populations eligible for medical services<br>Annual reporting processes by the Vendor at a timeline determined by the State<br>The Vendor should describe in detail how it will meet these specifications.<br><br>American Academy of Pediatrics (AAP) guidelines outlined in Health Care Issues for Children and Adolescents in the Foster Care and Kinship Care technical report can be reviewed at the following location: https://publications.aap.org/pediatrics/article/136/4/e1142/73872/Health-Care-Issues-for-Children-and-Adolescents-in |

**We are actively engaged in expanding the availability of Patient Centered Medical Homes (PCMH).** Children entering foster care or who are going through the adoption process often have a history of receiving inconsistent health care or none at all due to frequent moves or because their family of origin had not maintained consistent relationships with providers. They have experienced not only the emotional trauma that resulted in their entering the child welfare system, but often have chronic medical conditions, mental health issues, or developmental disabilities that have not received adequate treatment. A key protective factor and element of resiliency is the presence of continuity in the life of a child. PCMHs can be a key driver of consistency. Figure E.2-7 identifies the qualities of a PCMH with added emphasis for elements critical for foster care children, according to the AAP.




We recognize the extensive and lengthy process for providers to be formally recognized and certified as PCMHs and that the provider network in West Virginia does not currently have the necessary volume of PCMHs for members, particularly for those children in foster care. Our provider representatives work with providers and community resources to strategize regarding expansion of PCMH providers throughout the state. We have been successful in developing a PCMH with Marshall University and are assessing two other PCMH entities. We have a nurse care manager who conducts on site visits and participates in a monthly clinical case discussion call with Marshall University. **The Marshall University PCMH has demonstrated 17% improvement in Childhood Immunizations (combo 3), 16% improvement in follow up after discharge from a behavioral health facility, and 11% in postpartum care.**

## Provider application process

We strive to both identify and support our existing medical home providers and help provider practices desiring PCMH certification. We collaborate within our network development team, CAT administrators, provider relations staff, alternative payment model (APM) services contracting representatives, and population health experts to outreach community providers and offer education regarding the certification process, understanding the time, effort, and cost that goes into this process. We investigate provider interest, who has the best potential to pursue certification, and partner with FQHCs who may have additional experience in this area. We consider options with behavioral health providers who may be able to expand into and integrate physical health services.

## Continuity with medical home of origin

As part of our initial screening processes, care coordination staff inquire with the member and their family regarding where the child has received health care in the past and whether they have been happy with those services. If the child and family have been receiving services at a medical home with whom they are happy and with whom Aetna contracts, the child can continue to receive care in that medical home if that is their request. If they are unhappy with the care they have received, care coordination staff explain the availability of contracted providers and PCMHs in their area (as well as

what the role of PCMH entails) and connect them to the PCMH or provider of the member and family's choice.

If the member has been receiving care from a PCMH that they would like to continue with who is not currently in our network, the care coordinator coordinates with our network team to pursue an out-of-network single-case agreement and/or contracting process with the provider. The member's services will remain in place with their medical home for a minimum of 90 days during the contracting phase.

## Member communications regarding availability of PCMH

Aetna provides information to members regarding the availability of PCMHs through multiple avenues. The member handbook contains information regarding covered services, inclusive of PCMHs and the benefits of that model. Additionally, our provider directory contains an indicator to highlight PCMH providers. Finally, Care Connection teams inform members and their families of the PCMH model and available providers for those children who may most benefit.

## Annual reporting process

We comply with all annual PCMH reporting processes. Currently we deliver regular reporting on providers with PCMH deliverables such as care coordination, integrated services, and appointment availability, to name a few. We are also tracking existing medical homes and provide the State with the number of medical homes identified and the members attached to a medical home on at minimum a quarterly basis.

## Adverse childhood experiences and trauma-informed care [CM13]

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| CM13 | The Vendor should develop policies and procedures that reflect how the Vendor will train staff and providers to recognize, understand, and respond to the effects of all types of trauma, per American Academy of Pediatrics (AAP) guidelines for a trauma-informed practice.<br><br>The Vendor should also include a process to implement trauma-informed care guidelines for working with youth who may have been exposed to ACEs.<br><br>Information from the AAP regarding trauma-informed care and ACEs can be found at the following link: https://publications.aap.org/pediatrics/article/148/2/e2021052580/179745/Trauma-Informed-Care<br>The Vendor should:<br>1) Provide proposed policies, procedures, and/or guidelines reflecting how the Vendor will use of trauma-informed care.<br>2) Describe direct experience working with youth who may have been exposed to ACEs. |

The American Academy of Pediatrics (AAP) and the Adverse Childhood Experiences Study have confirmed that exposure to severe stress and trauma such as abuse, neglect, discrimination, bullying, racism, household SUD, sex trafficking, and community or domestic violence increases an individual's risk for serious and lifelong physical and behavioral health issues, poor health outcomes, reduced quality of life, and increased cost of care. Exposure to toxic stress and traumatic events as a child can result in poor performance at school, inability to maintain employment, inability to sustain social relationships, and place young people at risk for future homelessness and justice involvement.

We have committed to addressing ACEs in West Virginia as demonstrated by our work as a key partner with the state to create the **WV ACES Coalition** eight years ago. The ACES Coalition of West Virginia **includes over 600 stakeholder, provider, educational, and advocacy organizations and individuals with lived experience working together to improve the health and well-being of all West Virginians by reducing the impact of ACEs.** The Coalition meets six times a year, every other month and each meeting spotlights the work of an ACEs coalition member specific to a TIC initiative

they are implementing. We have spotlighted school systems, medical providers, residential providers, and numerous other programs across the state. Coalition meetings also include sub-committee Task Teams meetings. The task teams have implemented initiatives and facilitated community events related to Training, Awareness, Programs and Services, Legislation, and Research on ACES and trauma-informed care (TIC). Through the Coalition, we also issued surveys to Coalition members and Aetna providers to assess what types of TIC training were already available, and what was still needed in the community.

The Coalition has joined a national movement led by Positive and Adverse Childhood Experiences **(PACES) Connection –known as Cooperative of Communities**. This is a program that provides special tools, services, workshops, and surveys for PACEs initiatives in neighborhoods, towns, cities, counties, regions, states, and countries with ACES coalitions.

## Trauma-informed care training for staff and providers

Due to our extensive work and growth in understanding ACES and TIC, we have developed effective training protocols and curricula for our staff and providers, in partnership with our CAT administrators and the WV ACES Coalition. This curriculum includes **Connections Matter, ACEs 101,102, and 103 training modules** which collectively cover ten types of ACEs, the impact of ACEs on youth and adults, and ways to prevent and overcome ACEs (protective factors and resilience).

We initially **trained all Aetna Care Connection teams, member services, and community outreach staff in ACEs and TIC** through a partnership with the National Council for Behavioral Health. Our staff have more recently attended ACEs 101, 102, and 103. Our learning and performance team also offers additional ACEs/TIC training to our staff. Additionally, we recognize that our member-serving staff may experience secondary trauma during their interactions with members in the Mountain Health Promise program. **To promote staff wellbeing and retention of our workforce, we provide the following:**

- "Good morning" messages for Care Connection team staff that includes a self-care challenge or tip
- Mindfulness resources
- Providing lunch and learns regarding mindfulness at work
- Vicarious Trauma and Compassion Fatigue training
- Debriefing sessions after every clinical case round for foster care members
- Flexible scheduling

We are committed to network capacity-building in TIC in West Virginia. We offer our providers the same ACES and TIC training modules we described for our staff training above and offer virtual ACEs and TIC trainings to providers through our provider portal. We have also completed train the trainer on ACES and TIC with 30 stakeholders to deliver the ACEs curriculum.

## Trauma-informed guidelines to serve children and youth with ACEs

We do not dictate to providers which clinical models they must use in working with youth with ACEs. However, our various training curricula do introduce clinical guidelines and approaches for ACEs/TIC, and we survey providers regarding which clinical models they use and are trained in. Additionally, Aetna expects that providers organize their practices and agencies to align with the **AAP's Trauma Toolbox and Helping Foster and Adoptive Families Cope with Trauma: A Guide for Pediatricians** resources which offers detailed information regarding identifying and responding to trauma.

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## Experience working with youth who may have been exposed to ACES

Because a significant number of members in the Mountain Health Promise program have experienced trauma, we have ample experience in day-to-day care coordination with youth who have been exposed to ACEs and have conducted almost **4,700 ACEs assessments**. We also have experience coordinating with local partners to address ACES. For example, we partner with the Child Advocacy Center located on the campus of Women and Children's Hospital in Charleston to promote communication and notification protocols so we are immediately aware if a member in the Mountain Health Promise program has been exposed to trauma so our Care Connection team can immediately engage with the member/family/guardian and help. The goal of this partnership is for the center to notify us immediately if one of our members (child and adolescent) has been potentially exposed to trauma. We have also broadened **partnerships with Family Resource Centers (FRC)** across the state to encourage their membership in the WV ACEs Coalition and to participate in bimonthly training and resource sharing discussions. Additionally, one of the FRC Directors in on the Coalition's Board of Directors.

[redacted]

His mother left him at a young age, and he found his brother's body after he committed suicide. He had trouble processing his emotions and became physically aggressive due to not understanding "feelings" and being unable to share with his family what was going on inside his mind. He ended up going to court due to aggression at school and was placed in a detention facility for testing. His family applied for CSED for him, and he was approved for waiver services. We enrolled him in Tier 3 intensive care management and his Aetna care coordinator completed a comprehensive assessment including the ACEs-Q. Martin's responses to the assessment revealed that he still needed to process his feelings regarding his brother's death as well as other issues. We connected him with Applied Behavior Analysis (ABA) treatment. The ABA provider diagnosed Martin with Autism and assisted not only Martin, but his family. We also arranged for grief therapy for Martin and his family through the local hospice office. After Martin began ABA therapy and grief counseling, he was able to utilize a chart to let his family know when his emotions were getting out of control and learned ways to help regulate them. Martin and his family now have a better relationship and are thankful for the supports that they have in place.

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## Telehealth and other technology solutions to support care coordination [CM08]

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| CM08 | The Vendor should use technology, including, but not limited to, telemedicine, telehealth, and telemonitoring services to improve quality and access to care.<br>1) The Vendor should describe how it would use these services.<br>2) The Vendor should provide examples of successful use of these services. |

**Telehealth:** Telehealth, telemedicine, and telemonitoring services, collectively referred to as "teleservices", are effective service delivery options which improve access to care for members in rural areas, those with mobility or transportation barriers, and for services where network gaps may exist. Teleservices are proven to increase treatment adherence, decrease both inpatient and ED hospitalization utilization, reduce disease burden in communities, and promote the concurrent use of advanced specialty capabilities in coordination with a member's PCP, thereby improving available quality and continuity of care. Teleservices have also been critical in to ensuring members could receive care during the Covid-19 pandemic. **Prior to the pandemic, only about 1% of services for our members were teleservices, but at the height of the pandemic, 16% were delivered via teleservice. Aetna facilitated about 27,700 telehealth visits from July 2021 to June 2022, with 86% of the visits involving a behavioral health diagnosis.**

**Most teleservices for members in Mountain Health Promise are delivered by local providers who use their own teleservice platforms.** All teleservice provision and reimbursement comply with state requirements related to allowable service types, provider types, and technology. We also supported providers' expansion of teleservice delivery by **supplying cameras/equipment** to several provider organizations. We continue to support the use of teleservices across our medical benefit as well as explore the opportunities to bring in additional providers to meet capacity and specialty concerns identified. For example, we offer **Groups Recover, PursueCare, and Bright Heart Health for SUD and MH virtual services and are contracting with Flourish Health** for more serious mental health issues. We also intend to contract with **Twentyeight Health** for virtual prescribing of contraception, emergency contraception, and sexually transmitted infections, if approved by the state.

### Expanding access to timely behavioral health assessments

Community Care of WV, a leading provider of evidenced-based behavioral health services for children and families, is partnering with Aetna Better Health in the treatment of their most vulnerable youth

Through this partnership, Community Care will provide urgent psychiatric assessments using telehealth and traditional office visits when MHP members are having difficulties in their current settings or when they visit an emergency rooms where behavioral health assessments are not readily available.

We are committed to making teleservices accessible to West Virginians. To make it easier for members to utilize teleservices, Care Connection teams and community health workers refer members to the federal Affordable Connectivity Program which offers programs to reduce the cost of internet services and/or the purchase of a device.

**FamilyConnect:** FamilyConnect is our electronic care coordination system and houses member assessments, care plans, and appointment information. FamilyConnect is the single source of truth for youth and their circles of support. Members and their guardians/caregiver(s) may access FamilyConnect through the member portal on a computer or with a mobile device.

**Outbound text messaging:** Our educational text-messaging program delivers targeted messages to remind members to get tests and screenings done. It sends routine reminders to members to support their health goals related to weight management, diabetes, substance use, prenatal and postpartum care, well-child visits, and flu shots. Many of these text campaigns serve as virtual health coaches and allow members to interact and be educated on their specific conditions. Some of the unique monthly broadcast messages we have sent to members include reminders on keeping contact information current with the local BSS office or even ED diversion and the importance of seeking their PCP first.

## Access to care and gap analysis [CM10]

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| CM10 | The Vendor should conduct ongoing gap analyses to determine the types of services and resources not available in the State and provide the State its strategies to address identified gaps on a quarterly basis. The Vendor should provide a detailed description of its approach to meeting this specification. |

**Addressing network gaps:** Our network team conducts network gap analysis on an ongoing basis to quickly identify and respond to service gaps. We identify gaps through analysis of member density and geo-mapping data to determine the provider types and services that are unavailable in particular regions or across the state. We also utilize reports and monitoring tools to identify gaps such as the availability of network practitioners report, emergency department utilization report, network panel

studies, and member and provider appeal and grievance data. We also factor in feedback from our CAT administrators in analyzing gaps. When we identify a network gap, provider services staff develop a plan to resolve the gap with contracting staff. There may be local providers who are well positioned to expand their array of services and just need additional technical assistance from us to develop these new programs and service offerings. There may be out-of-network (and out of state) providers who have delivered services on a limited single-case agreement basis who would agree to a formal contracting relationship with us at locations within the state. Provider services staff collaborate with care coordination staff, CAT administrators, existing providers, community partners, and network counterparts at the Department to strategize and create the plan to develop the needed services in the regions where they are most needed. Should a network gap arise, we will comply with all requirements to communicate with the state on a quarterly basis regarding our strategies to resolve the gap.




**Access to care standards:** We established provider access to care standards in alignment with required time, distance and appointment wait time standards as outlined in Appendix 3 (Model Service Provider Agreement) Section 3.12, Availability and Access Standards and Appendix K. We contractually require all participating providers in our network to adhere to timely access and appointment standards, including specific standards for specialty, urgent, and crisis services. We monitor adherence to these standards through a variety of mechanisms including, but not limited to:




- Geo-mapping analysis
- Evaluation of provider to member ratios, hours of operation and appointment availability and after-hours coverage
- Provider surveys and site visits
- Member satisfaction surveys
- Review of closed primary provider panels
- Complaints

When we identify providers who are not meeting the access standards, quality management and provider services staff implement a series of steps (with progressively greater significance) to help providers achieve compliance. This includes the provision of technical assistance and analysis of barriers to achieving compliance and assistance in the creation and tracking of CAPs when necessary. Providers who continue to fail to meet the standards may be referred to our Service Improvement Committee, the Quality Management Oversight Committee, and ultimately may face network termination.

When a care coordinator and ICT identify that a member's care is impacted by network gaps or a providers' inability to meet access to care standards, we mobilize resources to identify solutions. The care coordinator may involve the network or provider relations teams to identify alternative provider options or to consider possible out-of-network single case agreements with providers who can meet the member's needs within timeliness expectations.

## Member materials, education, and outreach strategies [CM18]

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| CM18 | At no additional cost to the State, the Vendor should provide targeted education programs, member materials, and outreach strategies for their enrollees, community advocates, and stakeholders that are appropriate for both adults and children and identify who will receive these programs.<br>All materials should adhere to federal and State marketing regulations.<br>The Vendor should:<br>1) Describe its approach to targeted member or medical management education programs.<br>2) Identify the audience for each program.<br>3) Provide the time frame for creating education materials and educating community engagement and care coordination staff. |

We offer **member materials, outreach, and targeted education** to assist members and their families/guardians with system navigation, self-sufficiency, and realization of their health care goals. We also provide **education to community partners and stakeholders** to broaden their ability to assist members.

## Development of member materials and outreach approaches

We create member education materials with the understanding that our young members have legal guardians and extended family, or caregivers present in their lives due to involvement in child welfare. **Our materials educate members as well as their guardians/extended family/caregivers. We develop materials in collaboration with our community stakeholders such as advocacy and disability groups.** This strategy promotes adherence to legal informed consent for care and involvement with minors' requirements and promotes engagement with caregivers and children and youth. Health education experts regularly review content to ensure it is responsive to member needs and their unique backgrounds.

We develop all member materials, including letters, in compliance with the guidelines in 42 CFR 438.10, Section 4.4, "Materials" in the Model Service Provider Agreement, and state and federal marketing requirements. This includes language with a reading level no higher than sixth grade, readable typeface, frequent headings, and short, simple explanations. We ensure that our electronic information is easily accessible and is presented in a format that can be retained or printed. Written material must be available in languages of the major population groups served, and in alternative formats such as braille. Members (and/or guardians) who require copies of assessments, care plans, or other documentation related to their care in a different language or format receive these.

**Our member materials targeted to children and youth include age-appropriate photos and language that is even more simplified than sixth-grade level, with heavier use of imagery and pictures as compared to materials for adults. Materials for older children, young adults and their families/guardian contain more complex explanations and information.**

With respect to outreach in the context of care management, we make up to five attempts to reach a member and/or their guardian when conducting the initial screening. Additionally, we conduct similar outreach attempts with members (and their families/guardian where appropriate) who are not attending assessment appointments, care planning meetings, or who have missed health care appointments. Should our telephone and face to face efforts to contact the member fail, we send a letter to the

member (or their guardian where appropriate) inviting them to contact their coordinator to discuss solutions to resolve barriers to attending ICT meetings or services.

## Targeted education

We provide targeted member education to deliver information to members and their families/guardians which helps them better manage chronic conditions, offers them education and encouragement to learn self-management skills, and provides information to access the appropriate services and supports. We educate and support members to prevent exacerbations of conditions and prevent hospitalizations and other high-cost health care resources.

We have created a large library of printed and web or electronic-based materials however, we are **continually reviewing existing materials and adding new materials**. We train our community engagement staff and care coordination staff new education campaigns and materials are finalized so they are immediately 'in the know' about new available educational resources. Community engagement staff meet on a weekly basis to review member education materials and discuss the best way to present the material. For example, training may include strategies for presentation of material with an understanding of the culture in which the region will be presented. With many native West Virginians on our team, we are knowledgeable about these regional cultural differences and understand adapting our presentation style in the context of these differences helps to better convey education material.

In this section we provide descriptions of a few member educational materials and campaigns already available for members in the Mountain Health Promise program. Many are geared toward young adults or the guardians of child and youth enrollees, however some specifically target younger children/youth.

**Written member educational materials:** We have several educational pamphlets covering a variety of topics. These are written with an adult audience in mind but are relevant for the types of health issues children, youth and young adults in the child welfare system may be impacted by. Educational pamphlet topics include the following:

- Getting Ready for Baby
- Staying Smoke Free
- Depression After Having a Baby
- Your Baby's Development
- What To Do if Your Child Has a Cold
- Krames educational materials on such varied topics as sexually transmitted infections, mental health, pediatrics, nutrition, dermatology, and dental services, among others.

**Technology-based member education:** We inform members about our technology-based education options through the member handbook, our website, and contact with member services staff. These options include several applications which send personalized text messages free of charge to members on the following types of topics:

- mPulse Mobile: sends message regarding needed preventive screenings and immunizations
- SMART Recovery Teen Mobile app: provides tools and real-life solutions to common SUD recovery roadblocks
- Pyx Health: pairs a texting promotion campaign with mobile experience and support center designed to address loneliness and social isolation

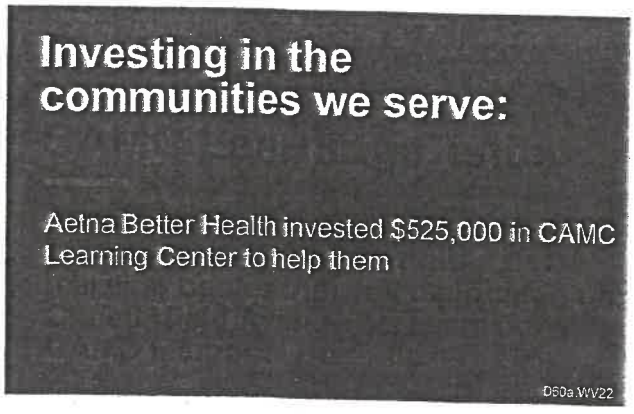
**Educational programs and workshops for members:** Aetna's **Ted E. Bear, M.D.SM Cub Club**, a value-added service, provides children up to age 13 with health education regarding diet, exercise, and daily hygiene. Currently, approximately **225 members** in Mountain Health Promise are members of the Cub Club. We send members notifications and challenges related to attending appointments and practicing **healthy behaviors** such as brushing teeth, getting a healthy amount of sleep, and eating five servings of fruits and vegetables daily. We specialize Cub Club materials for children and provide **member rewards** (such as blankets or a dental kit) for completion of challenges, activities, and program graduation. We also have an annual Ted E. Bear, M.D.

Hot Shots is an activity for Cub Club members ages 0 to 2 to encourage **completion of the recommended vaccines** in the Childhood Immunization Series (CIS) HEDIS® measure. Big Shots is targeted for Cub Club participants ages 9 to 13 aiming to improve the Immunization in Adolescents (IMA) HEDIS rate. Finally, Flu Fighters is geared towards Cub Club participants who are 2 to 13 years old. Participants who complete these programs receive a small additional reward outside of the usual Cub Club rewards.

We offer our **Foster Care HEERO (Helping Each Other/Everyone Reach Out) ™** workshops to children and families in the community. HEERO™ is a practice approach for transition-aged youth that recognizes the importance of relationships in overall health and wellbeing. These workshops offer participants education regarding the effects of trauma on health, tools that families can use to create supportive networks of peers, family members, and friends, an overview of the Family First model, and tips to strengthen community connections to support child safety and health goals. Attendees learn how vulnerability, courage, and worthiness can lead to opportunities, bravery, and pride. HEERO™ connects people with shared lived experiences and fosters an environment where they can empower one another.

Aetna, the Court Appointed Special Advocates (CASA), Children's Home Society (CHS), Florence Crittenton, Monongalia County Youth Services Center, Board of Child Care, and Dan Martin, the founder of HEERO™ has **hosted eight HEERO™ workshops** for foster youth workshops in several locations across West Virginia. **25 youth participated and 20 network meetings were established.** HEERO workshops have empowered several teams to ask the Commissioner if they can share their experiences to better shape WV laws and policies.

**Education for community advocates and stakeholders:** We offer education to BSS caseworkers on how to use FamilyConnect and have provided training to stakeholders on CAFAS, discharge/level of care planning, and ACEs/TIC. As another example, we have close relationships with the West Virginia Family Resource Network in each county. We leverage these relationships to get involved at the community level and respond to local needs and through collaborative projects. Our Community Engagement staff attend monthly Family Resource Network meetings in each county and provide presentations on the Mountain Health Promise program.



## 3. Community/Stakeholder Engagement

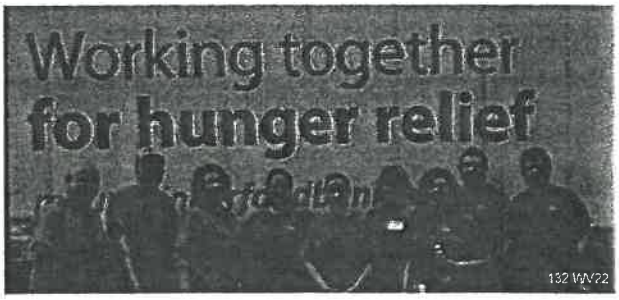
Consistent, meaningful engagement with communities and stakeholders in every part of the state is critical to our success in serving West Virginia's most vulnerable residents. Our **locally based, seasoned, and expert West Virginia team** is a trusted and engaged community partner in West Virginia, working hand-in-hand with local communities to advance member health and well-being. We've served the needs of West Virginia Medicaid members since 1996, including coordinating care and benefits for approximately 28,000 children and youth in Mountain Health Promise since March 1, 2020. **We've partnered with the Department of Health and Human Resources (DHHR) for a total of 26 years to serve West Virginians in all 55 counties and look forward to continuing our relationship.**

Aetna Better Health® of West Virginia (Aetna) has diligently worked to **build and maintain deep relationships with West Virginia community organizations and stakeholders** in the child welfare system to leverage combined efforts to improve the lives of our members. We've established various mechanisms to collaborate with stakeholders and have expedited communication protocols to ensure quick resolution. We look at all available data sources to inform our stakeholder initiatives so that we are intentional and meaningful in our efforts, including county health rankings, Community Health Assessment Priorities, and the Behavioral Risk Factor Surveillance System Report. An example is our use of social risk analytics to identify counties with elevated risk and resource gaps for food insecurity, so that we can develop innovative solutions with our partners such as the Mountaineer Food Bank.

**Collaborative Partnership in Cabell County Addresses Food Insecurity**

Thousands of our members in Cabell County between Huntington and Barboursville live in areas at elevated risk of food insecurity. To address this challenge, we partnered with Cabell Family Support Center, Facing Hunger Food Bank, and Parents as Teachers to serve more than 1500 individuals through a mobile food pantry initiative. Health education activities, including supper in a sack; cooking with commodities; budgeting; canning and other food related topics; and cooking demonstrations have impacted 30 households.

Our ongoing collaboration with all West Virginia stakeholders in the child welfare system has **helped to serve children and youth in the least restrictive setting.** We've aligned our goals with the West Virginia Department of Justice (DOJ) agreement. Our efforts to assist Child Protective Services (CPS) and Youth Services (YS) and partnership with residential treatment providers have contributed to a 10.8% reduction in residential in-state and out-of-state placements between February 2020 and August 2022. The state has already exceeded the DOJ's end-of-year goal for the number of youths in group residential treatment facilities. As of October 2022, there were 662 youth in these facilities compared to the DOJ's goal of 689 by December 31, 2022.




**We are West Virginians** with a shared cultural richness and deep roots in our communities, schools, and places of worship because the Mountain State is where we live and raise our families. Our **longstanding presence across West Virginia** and knowledge of those whom we serve allow us to uniquely leverage our expertise to address health care disparities and improve health equity. Being in and of this region affords our members the opportunity to rely on the trust we have built with their families in support of their deep desire to keep their children safe and well cared for. We're committed to assisting all West Virginia

families struggling with poverty, addiction, limited resources, and other social determinants of health (SDoH) barriers, such as transportation, internet, and cellular access. Our work with West Virginia families is an excellent example of how **we draw upon our lived experiences within our own communities to meet the needs we see our neighbors struggling with.** For this purpose, Aetna care coordinators are purposely located in and around West Virginia.

The following table lists the stakeholders and community-based organizations we currently partner with to support Mountain Health Promise. For example, **we partner with the West Virginia State University Healthy Grandfamilies program** to provide education and support to grandparents who are raising their grandchildren. At least 50 families have received education and health literacy support, as well as information to address the mental health and social isolation needs of children who have parents with active addiction. Another example is **our partnership with the United Way of Central West Virginia and West Virginia 211** as evidenced by their letter of support that states: "We know that Aetna cares about West Virginians because of their level of involvement in all of the communities they serve. They maintain positive relationships with other agencies, participate in community events and meetings, and are knowledgeable about the needs of their members."

> "The WV Foster, Adoptive and Kinship Care Network works with families across the state and has worked closely with Aetna to meet the needs of families. Aetna has enhanced child welfare in West Virginia by helping to track children's medical records and serving as an additional resource for families involved in the system. Families report that Aetna Care Managers have helped refer them to services they were previously unaware of, such as the CSED Waiver and medical specialists in their area. They have also helped with family-finding and identifying placements for youth who have historically struggled to find family-based placements. Members of Aetna's leadership team have continuously engaged with foster, adoptive, and kinship families and have demonstrated a desire for honest and transparent communication, including the challenges families face. They have conducted focus groups, maintained a Member Advisory Council, and met regularly with the WV Foster, Adoptive and Kinship Care Network to learn more about what families need and how the system can be strengthened to better serve youth and families. While onboarding Aetna during a global pandemic presented some challenges, they worked through them and supported families when they needed it most. Efforts to maintain and share data and build relationships with families should continue so all stakeholders can continue to work together to support children and their families in West Virginia. We look forward to continuing the partnership with Aetna."
>
> — *Marissa Sanders, WV Foster, Adoptive and Kinship Care Network*

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| Governmental | Bureau for Social Services<br>Bureau for Medical Services<br>Bureau for Juvenile Services<br>Family Protection Services Board<br>Office of Drug Control Policy<br>Job Corp<br>Substance Abuse and Mental Health Services Administration (SAMHSA) |
| Education System | Marshall University<br>West Virginia University<br>County Boards of Education |
| Legal | Family and Drug Treatment Courts<br>Legal Aid of West Virginia<br>Court Improvement Program<br>WV Court Appointed Special Advocates (CASA)<br>WV Center for Children's Justice, Handle with Care |
| Foster and Kinship Care | WV Foster, Adoptive and Kinship Care Network<br>iFoster<br>Mission WV |

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| Advocacy Groups | Coalition for a Tobacco-Free WV |
| | Drug Free Moms and Babies |
| | Jobs and Hope |
| | Opioid Response Network |
| | Socially Necessary Services (SNS) Provider Association |
| | To the Moon and Back |
| | National Youth Advocate Program |
| | WV Adverse Childhood Experiences (ACEs) Coalition |
| | WV Alliance of Recovery Residences |
| | WV Behavioral Health Providers Association |
| | WV Childcare Association |
| | WV System of Care |
| Community-based Organizations | Help 4 WV |
| | WV 211 |
| | WV Drug Intervention Institute |
| | West Virginia State University Healthy Grandfamilies |
| | Right from the Start |
| | Birth to Three |
| | Head Start |
| | ThinkKids |
| | WV FRNs |
| | WVU Extension |
| | WV Reentry Councils |
| | Youth Services System |
| | Parents as Teachers |
| | Regional Transition Navigators |
| | WVU Center for Excellence in Disabilities |
| Providers | WV Perinatal Partnership |
| | WV Medical Cannabis Advisory Board |
| | DynamiCare Health |
| | Marshall Health |
| | National Association for Addiction Professionals |
| | WV Association of Addiction Counselors |
| | WV Certification Board for Addiction and Prevention Professionals |
| | WV Child Care Association |
| | Child placement agencies |
| | Residential Treatment Facility (RTF) level 1, 2, and 3 providers |
| | SNS providers |
| | Psychiatric RTF providers |
| | Medical doctors and their office staff |
| | Free clinics |
| | Child emergency shelters |
| | Substance Use Disorder (SUD) treatment providers |
| | Federal Qualified Health Centers (FQHC) |
| | Children with serious emotional disorders (CSED) waiver providers |
| | IDDW providers |
| | Psychologist, therapists, and counselors |
| | Comprehensive Behavioral Health Providers |
| | KidLink/Acadia |
| | Golden Girl Group Home |
| | Bright Heart Health |
| | PursueCare |
| | Groups Recover Together |
| | Flourish |

**Aetna has established several formal mechanisms to engage and receive input from the communities and stakeholders we serve**, including:

- **Member Advisory Committee (MAC).** Our voluntary MAC, comprised of foster, adoptive, and kinship parents, met bimonthly for the first two years of the contract and now meets quarterly to provide critical input related to program needs with the goal of improving outcomes for foster youth and their families. This group discusses issues they're encountering and recommends solutions so we can make programmatic changes to improve the overall health of the program.
- **Grandfamilies Group.** We established our Grandfamilies Group to address the need we observed for grandparents to receive information on navigating the child welfare system. The creation of this group demonstrates our ability to quickly adjust to a need identified by our stakeholders. The group, which meets quarterly, includes grandparents who've adopted their grandchildren, grandparents who are fostering their grandchildren, and grandparents who've successfully launched grandchildren into adulthood. This group has a strong educational component based on the expressed needs of the members and allows us to engage grandparents as we develop strategies to meet the needs of the many children and youth cared for by grandparents and great-grandparents. As one group participant stated, "Thank you so much for linking me with legal aid assistance and the Birth to Three program. It was such a huge help." On average, 10 individuals attend each meeting to receive information from guest speakers, such as Pamela Kaehler, Director of the WV Foster Care Ombudsman's Office; Ana Beltran, Co-Director of the National Center on Grandfamilies of Generations United; Marissa Sanders, Director of the WV Foster, Adoptive and Kinship Care Network; and representatives from WV Legal Aid.
- **Focus Groups.** In the Socially Necessary Services (SNS) focus groups and Residential Treatment Facility (RTF) focus groups, we obtain feedback about member experience with service access, service delivery, gaps in the support system, engagement with system staff, cultural competency, and member knowledge of services and supports using questions developed by the Bureau for Social Services (BSS) for report in the Annual Progress and Services Report. Mountain Health Promise staff are required to contractually facilitate six focus groups, however, we have been targeting 12 SNS focus groups per contract year and the RTF focus groups on a quarterly basis.

**Focus Group Identifies Need for Foster Parent Training on Needs of LGBTQ+ Members**

At a focus group facilitated by Aetna Better Health, which included mostly foster parents providing services for the same Child Placing Agency (CPA), many of the foster parents expressed a lack of knowledge of the healthy sexual development of LGBTQ+ children and the importance of asking about and using the correct pronouns. They further stated that if they knew more about the subject and felt competent, they would be more likely to accept placement of LGBTQ+ children. As a result, the CPA provided training to all foster parents with the CPA on LGBTQ+ children's needs and how to better serve them. It is our hope that this will result in more LGBTQ+ children in family settings instead of residential facilities and shelters, especially in the two regions served by the CPA.

- **Provider Collaboration.** Our outreach and collaboration efforts with provider industry stakeholders and associations include monthly Behavioral Healthcare Provider Association meetings where we update providers on any changes in Mountain Health Promise, and we advise, discuss, and problem solve issues raised by members of that association. As we rolled out the children with serious emotional disorders (CSED) waiver, we worked with this association to improve provider understanding and enrollment in this community-based program. We also meet weekly or biweekly with each of the community partners that provides emergency shelters and/or diagnostics. We meet with in-state providers at provider-specific meetings such as foster care, levels I and II, and country road meetings. We also put "Faces to Cases" at least monthly at our meetings with the out-of-state residential/psychiatric residential treatment facilities (PRTF) providers (e.g., Acadia and

KidLink). We discuss youth in need of placements, barriers a facility is experiencing, and creative ways to network.

At Aetna, we're using our scale, expertise, and innovative spirit to advance the health care experience and **invest in community health at the local level in West Virginia.** Our strategy to invest in the health of West Virginia communities is grounded in four pillars: Healthy People, Healthy Business, Healthy Community, and Healthy Planet. We support communities across West Virginia in a variety of ways, including donations from our company and from the CVS Health Foundation. We also support charities through in-kind product donations, gift card donations, and sponsorships. A key component of our approach is identifying and mitigating gaps experienced by our partners so they can most efficiently support communities. Some of our alliances in the state include:

- **Food Pantries.** We provided $23,750 to fund multiple mobile food pantry events throughout the state, including partnership activities with Mountaineer Food Bank (Gassaway). These events allowed fresh food to get directly to individuals, which is particularly important for those food pantries without refrigeration. Our mobile events expanded due to the COVID pandemic.
- **Golden Girl Group Home (Ceredo).** Our workforce initiatives funded $15,000 to the Golden Girl Group Home in 2021 and is creating workforce programs tailored to teen residents who are aging out of care. Trainings are specific to the types of jobs available in their regions. For example, Golden Treasures Consignment serves as an experiential training opportunity for participants near Ceredo.
- **Facing Hunger Foodbank (Huntington).** We provided $500,000 to enhance and expand the Facing Hunger Medically Indicated Food Box program to address the nutritional needs of people with diabetes and renal health needs within the Huntington/Cabell region. This funding also went to purchase a refrigerated vehicle to deliver the boxes.




Our strategic community partnerships have allowed us to **invest in workforce initiatives and the creation of affordable housing.** Since 1998, we've invested $3.7 million in affordable housing in West Virginia and have created or rehabilitated 550 affordable rental units. We also invest in workforce initiatives to ensure that at-risk youth, mature workers, veterans, and individuals with disabilities have access to work opportunities both inside and outside our company. We have 12 active partners in West Virginia that work with us on these efforts, including apprenticeships, high school programs, and on-the-job training.



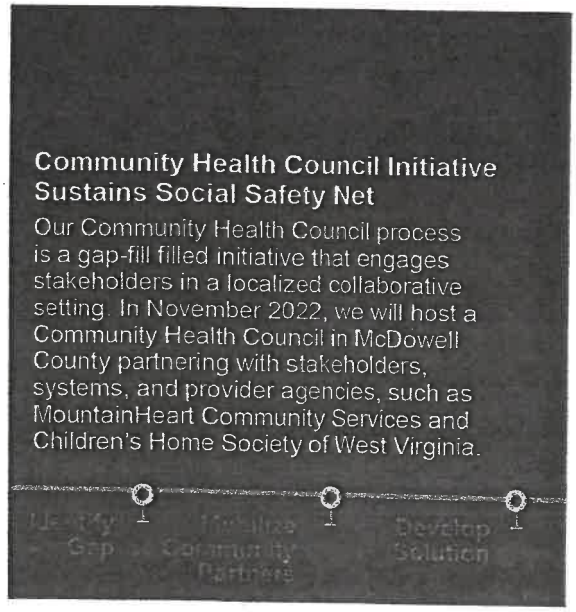
**Our in-store fundraising campaigns support national nonprofit partners that address key health disparities and chronic conditions**, including the American Heart Association, the American Diabetes Association, the American Cancer Society, Feeding America, and the Alzheimer's Association. Since the Feeding America in-store campaign began in 2020, we've contributed $70,245 to local Feeding America food bank partners in West Virginia. During 2021, we raised $154,544 from stores in West Virginia. Our colleagues are also

committed to giving back to the communities where they live and work, especially through volunteerism and have **logged many volunteer hours in West Virginia in 2021, which equates to $31,871 in donated time.**

## Approach to coordinating care with community stakeholders [CS01, CS03, CS04, CS07, CS08]

Aetna understands there are many West Virginia community-based partners and stakeholders that work collaboratively across the state to coordinate care for our members. Therefore, we've taken a multi-pronged approach to how we engage as an active partner with these organizations to ensure we coordinate the right care for our members at the right time. Our Better Together: SDoH Solutions, Care Advocate, and Community Engagement field teams work collaboratively both internally and with local partners to support community-driven solutions to coordinate care.

Our newly launched local West Virginia **Better Together: SDoH Solutions team** establishes partnerships across the state and implements innovative solutions to address identified gaps such as housing, food instability, employment, and education. This team is led by our Manager of Social Determinants of Health and Community Partnerships, Jordan Pruett, a West Virginia native who has worked in community development with Aetna in West Virginia for 10 years. His work led us to understand the importance of focusing on SDoH, not only for our members, but for the benefit of the entire community. We take grassroots, boots-on-the-ground approach and invest our time to build strong relationships with people, organizations, and systems to improve the health and well-being of children and their families in the child welfare system. Data and stakeholder feedback inform our activities and initiatives to sustain the social safety net.




The Aetna **care advocate team** (CAT) is led by our Social Services Director, Margaret Heasley, who worked as a clinical social worker for nearly 30 years, serving foster children in West Virginia across school and medical settings, including three years at Aetna. This team actively engages stakeholders to ensure efficient and effective care coordination so that we meet each child's individual needs. This team includes a network of community and plan-based services and supports the organization to meet the needs of members and families involved with multiple service agencies, such as child welfare, mental health, school, justice, and health care systems. Our community engagement and collaboration with numerous local, regional, and state-level partners in the child welfare system allow us to support a centralized and streamlined system of care for children and youth across West Virginia regardless of how a child enters care. We hold special review meetings, usually within 24 hours of the request, which bring together all key partners, such as the WV System of Care, Children's Home Society emergency child shelter staff, Safe at Home providers, and other members of the child's multidisciplinary team, including caregivers, extended family members, and the child's advocates to review a child's needs and determine the least restrictive, optimal placement and service array. **Since March 2020, our CAT has completed 611 Mountain Health Promise stakeholder events and trainings.**

Aetna builds local teams from within the communities we serve, and our engagement with these communities is a critical element in our overall model. Our local West Virginia **community engagement team** is led by our Director of Community Engagement, Jim Smallridge, who has been in his current position for 10 years. This team leads activities to educate members on health plan benefits and achieve health education goals through various efforts, including marketing projects, new market initiatives, health fairs, community trainings, and member retention activities. This team provides a wealth of information to our members and the community about covered benefits and other key product offerings through various methods, such as tabletop events, baby showers, back-to-school activities, and other special events.

**Aetna's approach to coordinating care with community stakeholders has enhanced our ability to serve children and youth in the least restrictive setting.** For example, we're using the Child and Adolescent Functional Assessment Scale (CAFAS) tool for all youth in shelter care and at in-state residential facilities to evaluate their functioning to ensure placement in the correct level of care. If the CAFAS indicates that a child isn't in the appropriate level of care, the care team immediately addresses the barriers that are keeping the youth in the facility and work to transition the member into community and family environments. We've aligned our goals with the West Virginia DOJ agreement. As such, we've collaboratively worked with the BSS and residential treatment providers to **reduce the number of youths in group residential treatment facilities from 844 in February 2020, to 662 as of October 2022, which exceeds the DOJ goal of 689 by December 31, 2022.**

## Coordinating care across child-serving systems

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| CS01 | The Vendor should coordinate care across child-serving systems, including, but not limited to the educational system, community services, and after-school programs.<br>The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of child-serving systems in the State. The Vendor should describe how it will accomplish care coordination across the identified and similar entities. |

Aetna coordinates care across child-serving systems, such as education, community, and after-school programs at the local, regional, and state levels, in the interest of improving care coordination for individual children and families while simultaneously ensuring larger-scale system change. We also provide access to legal assistance for our members and their families through a dedicated attorney and paralegal at Legal Aid of West Virginia. At the local level, **our care coordinators connect directly with teachers, after-school care providers, and other community providers** to request that they join Aetna-facilitated member care teams and involve them directly with any necessary interventions. Our regional and state leads meet and engage with community-based education and after-school leaders to hear their perspectives on unmet needs for West Virginia families and participate in stakeholder teams. These leaders' involvement as stakeholders helps remove the barriers children face in achieving success with schools, access to after-school activities, and link to effective community-based programs.

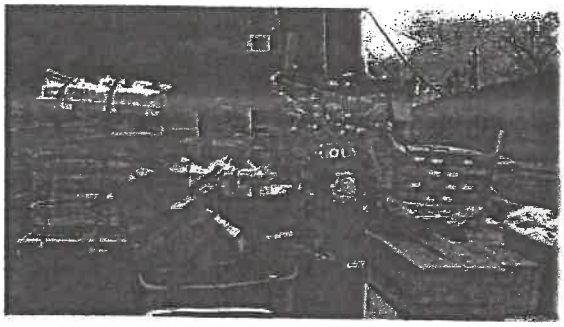
### Educational system

Aetna works closely with all West Virginia school systems to improve access to care. Our established relationships support a seamless transition of care if the student should transfer to another school or school district. The following are the key components of our strategy to coordinate care within the educational system:

- **School-based Health Centers.** We contract with school-based health centers (SBHCs) across West Virginia, one of the largest networks of school-based providers in the nation, to provide preventive, acute, and behavioral health care. The member's care team also accesses school-based resources to help address a child's behavioral needs.

- **Care Coordination.** Our care coordinators outreach to students and their family members to provide overall care and support. We regularly touch base with schools serving children and youth in the child welfare system to inform school staff of the child's care plan, living arrangements, and any challenges the child is facing.
- **Behavioral Specialist Intervention.** We support teachers and classroom aides with environmental interventions. Our behavior specialists instruct teaching staff how to intervene with escalated situations, how to prevent escalations, and how to manage classroom dynamics that can lead to disruptions, suspensions, and even expulsions. This type of environmental and skill-building classroom assistance is best accomplished through collaboration with school administrators, school counselors, and teachers.
- **Screenings and Health Education.** We also work with school nurses and SBHCs to provide screenings and education on various health care topics, such as healthy eating and the importance of wellness exams and flu shots. We've attended school registration events where we provide wellness and immunization information to parents. We provide our communications to the community at large, not just our plan members.
- **Head Start Collaboration.** We collaborate with West Virginia Head Start to engage parents by connecting them with comprehensive and essential services that promote health, wellness, and education. Our Community Engagement Team works with head start and preschool programs across the state and serves on many of their advisory committees to provide plan benefit support in real time. **Since March 2020, we have participated in 72 parent and staff meetings** where we distribute easy-to-understand wellness information for discussion. Some of the topics include the importance of wellness exams, immunization schedules, healthy eating, and healthy activities and behaviors.

## Community Services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Since March 2020, we've sponsored or participated in more than **3,000 community activities throughout West Virginia** to invest in local programs and collaborate with local organizations to maximize our collective impact. We'll continue to build upon the resources we've already invested, including partnership development, and strengthen our collaborative reputation within the communities we serve. An example of this is that we frequently partner and engage with a variety of West Virginia community-based organizations to hold events that provide information and assistance to children, youth, and their families, such as back-to-school events that serve meals and distribute backpacks with school supplies.

We understand that our members must first have all basic needs met. Aetna coordinates with numerous local community-based organizations in West Virginia to address basic social care needs, resources, and informal support systems that families need in concert with formal medical and behavioral health services. **Our approach to SDoH, supported by our deep-rooted relationships with West Virginia community-based organizations, allows us to address social care coordination in multiple ways.**

- **Assessment.** We first assess the social care needs of both children and youth and their family members. Since March 2020, 76.1% of our members have completed SDoH screenings.

- **Connection and Referral.** We identify social care needs by using our SDoH platform to refer members to appropriate services and work with community-based organizations to quickly meet those needs together. We also work closely with state agencies to help connect families to statewide programs and services.
- **Education.** We provide plan information to support weeks-long PRIDE training hosted by our community partners, including participating in question-and-answer panel sessions to educate new foster families on available services.
- **Technology.** We've leveraged technology since going live to quickly meet member needs, including partnering with Unite Us, findhelp, and WV 211. For example, we connect our social care team with Aetna members identified through the WV 211 screening process to offer additional care coordination, resulting in a closed-loop referral process and timely receipt of community services. We're also partnering with West Virginia Health Information Network (WVHIN) to provide an integrated and seamless electronic data exchange inclusive of SDoH data along with the medical data exchange necessary for high-quality, patient-centered care.

Aetna has **close relationships with the West Virginia Family Resource Network (FRN) in each county**, as we've found this is a great way to get involved at the community level and respond to the needs and opportunities of the community through collaborative projects. Our Community Engagement staff attends monthly FRN meetings in each county and provides presentations on Mountain Health Promise. We provided virtual support for the FRNs during the COVID pandemic by hosting some of their meetings via the WebEx platform. **We've participated in more than 200 community events with WV FRN in 2022**, including community baby showers, back-to-school events, and health and resource fairs. We also collaborate with FRN stakeholders to solve urgent problems and work on initiatives related to substance abuse prevention, community development, early childhood programs, child abuse prevention, economic development, foster care placement, resource development, and food or non-food essentials assistance.

Aetna has **worked with TEAM for West Virginia Children** on multiple efforts. We're the first managed care organization (MCO) in West Virginia to pair with TEAM's Our Babies: Safe and Sound Campaign, which promotes infant safe sleep and preventing shaken baby syndrome. Our care coordinators regularly participate in Safe Sleep Training and distribute safe sleep educational materials to members during face-to-face visits, including the *Safe and Snug* children's book, Our Babies Safe and Sound Parent Education Kit, and the "This Side Up" onesies.




We began our **partnership with the West Virginia ACEs Coalition** in March 2020, and contract with them to provide all stakeholders in the state with training and resources on the trauma-informed care (TIC) approach. This effort has resulted in 17 steering committee meetings and training provided to all stakeholders at 15 statewide ACEs Coalition meetings. In coordination with the Coalition, we also launched a statewide TIC survey; created a statewide strategic plan; and developed ACEs 101,102, and 103, training curricula and offered these courses with Continuing Education Units (CEUs) statewide to all stakeholders with over 300 in attendance. **We recently completed a train-the-trainer program in September 2022 where we trained 20 stakeholders to conduct the ACEs 101, 102, and 103 trainings.** We also sponsored the first training

by the West Virginia Primary Care Association for school-based health workers regarding ACEs. Aetna is collaborating with the West Virginia ACEs Coalition on its engagement with the national movement **Cooperative of Communities**, led by the Positive Adverse Childhood Experience (PACEs) Connection, to provide specialized tools and resources to assist communities, such as jobs banks and the Community Resilience Tracker.

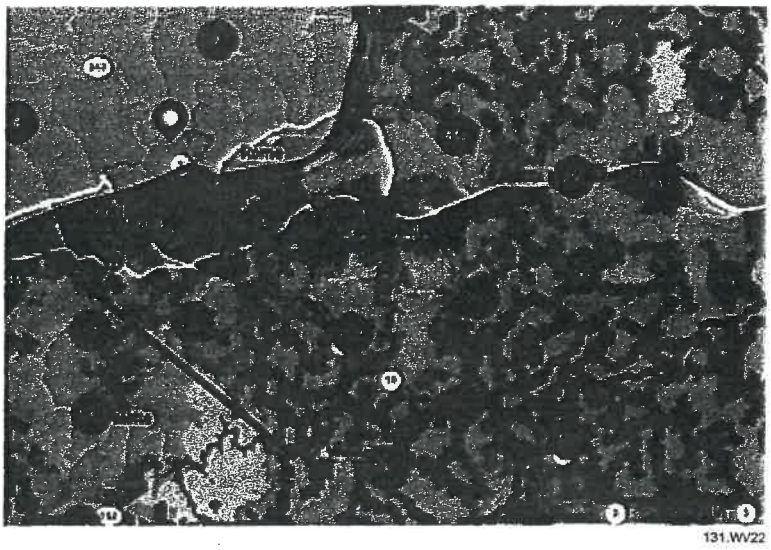
In October 2022, we offered seven ACEs workshops, including ACEs 101, 102, and 103, at the **Handle with Care National Conference in West Virginia** and sponsored the keynote speaker James Garbarino. Our Mountain Health Promise Medicaid Administrator, Kathy Szafran, and our Senior Medical Director of Behavioral Health, Dr. Frank Angotti, presented "Trauma Treatment isn't a Workbook Activity," focusing on the importance of developmentally appropriate TIC to ensure safety, attachment, and healing.




We **collaborated with the West Virginia University Extension** to provide health and wellness information to youth from McDowell, Mercer, and Wyoming counties who participated in the Snowflake Conference, a project that came from youth participating in the National 4-H Healthy Living Summit, funded by the Well-Connected Communities grant. Youth chose to focus on destigmatizing asking for help with their mental health as West Virginia ranks 39th with 21,000 (16.62%) youth having major depressive episodes, which is above the national average of 15.08%. It was important to promote health equity in these counties as the population in Keystone in McDowell County is 65% Black compared to 2.8% in the state overall.

**We work with faith-based individuals and organizations such as One Voice**, a nonprofit public charity that helps families and communities suffering from substance abuse. They've been instrumental in bringing communities together to educate, train, and mentor through community forums with support from the governor, U.S. and state senators and representatives, and the attorney general.

Aetna recognizes the relationship between health care disparities and food insecurity, especially in West Virginia with some of the highest rates of poverty and food insecurity across the nation. The devastating effects of poor nutrition on brain development and growth render West Virginia children at a major disadvantage early in life. We maintain longstanding relationships with food banks, including Facing Hunger and Mountaineer Food Bank, to address this issue. **We use multiple data sources to identify areas at particularly high risk for food insecurity and which may have restricted access to supports in the region to help mitigate those needs.** The following food risk map provides one example of how we use our social risk stratification tools to pinpoint where our members at highest risk for food security live. The numbers in the circles on the map indicate the number of members in the geography, with darker map colors representing higher risk. Our data indicates that our relationship with the Facing Hunger food bank in the Huntington/Barboursville region is critical to tens of thousands of members in this region. While the distance between Huntington and Barboursville is only 11 miles, 72% more members are at risk for food insecurity within that area than the 25 miles between Lavallette and Milton.




*Food insecurity social risk analytics- Huntington/Barboursville Region*

Examples of our initiatives to address food insecurity include:

- Participated in seven mobile pantry and food box packing events with Facing Hunger. In June 2022, we provided wellness information to more than 200 families in Huntington and provided them with fresh produce, meat, and pantry items during a Facing Hunger mobile food bank event.
- Participated in 10 mobile pantry and food box packing events with Mountaineer Food Bank.
- Provided funding to the Marcum Terrace Family Support Center in Huntington for their monthly food box distribution and after-school and summer feeding programs, with food purchased from Facing Hunger.
- Donated $500,000 to Facing Hunger to enhance and expand the Medically Indicated Food Box program to address nutritional needs of people with diabetes and renal health needs within the Huntington/Cabell region. This funding went to purchase a refrigerated vehicle to deliver the boxes.

We're also active with the following entities:

- Various city and county housing authorities, such as the Housing Authority of Mingo County, Housing Authority of Wayne County, Huntington Housing Authority, and Kanawha-Charleston Housing, to increase access to affordable housing; provide health care, prevention, and wellness information to residents; and serve as a resource for housing authority staff on Medicaid issues
- West Virginia Library Commission and numerous local libraries to assist with "read aloud" programs and to provide outreach and wellness programs
- West Virginians for Affordable Healthcare's Medicaid Matters group and sponsor of their Medicaid Summit promoting increased Medicaid enrollment
- West Virginia Healthy Kids Partnership to address health disparities and improve health outcomes

### After-school programs

Aetna actively participates in a **variety of after-school programs throughout West Virginia** to boost academic performance, promote physical health, and provide a safe, structured environment for the children of working parents. We support the after-school program at the Family Support Center in Huntington by providing educational activities for youth including story times and participate in the monthly food distributions for the center's families. We also provide resources to back-to-school events in the areas of Bradshaw, War, and Welch in McDowell County.

**Our members can join the WV 4-H after-school program at no cost which connects youth to mentors in a supportive and caring environment.** They also receive $50 annually toward the cost of activities and summer camp, which we'll increase to $100 annually. Foster care members can request participation through their care coordinator or the Member Services or Community Outreach departments.

**Partnership with WV 4-H Promotes Positive Youth Development**

Adriana, a Mountain Health Promise member, came to 4-H through the National 4-H Mentoring program. She lived with an older sister in an informal arrangement and was referred by her middle school teacher as needing a caring adult in her life. Despite financial and transportation barriers, she stayed involved after the initial year of mentoring as a 4-H member. She returned to 4-H as a teen leader mentoring younger youth and was the first person in her family to graduate high school. Adriana won a 4-H scholarship based on her excellent grades and essay. She attended Marshall University where she majored in education and is now doing her student teaching.

## Legal assistance

The lack of access to timely and tailored legal assistance is a significant barrier for foster children and their families and perpetuates a cycle of disparity. **Our members and their guardians have access to a dedicated attorney and paralegal though our contract with Legal Aid of West Virginia.** The attorney and paralegal provide civil legal services to stabilize the lives of our members and their caregivers. Examples of the areas that our members receive assistance with include guardianship, child custody and visitation, assistance navigating the abuse and neglect process, and housing issues. **Since March 2020, 192 members have received assistance through Legal Aid of WV.** Through our partnership with Legal Aid of WV, we make referrals to legal aid for educational purposes and have a program called Family Advocacy, Support, and Training (FAST). Due to the increase in educational referrals, the state has funded additional advocates to work the FAST program. Our contracted legal aid attorney also conducts outreach at various events, such as working the Kinship Care Hotline, presenting at the Caring for Kids in Care Conference, and hosting tables at Foster Family Appreciation days.

The benefits of offering legal services to all members and their families, include the following:

- Establishing permanent custodial relationships through representation in adoption, guardianship, or custody proceedings
- Increasing income supports for families, including navigating issues with government benefits or child support
- Removing barriers to employment by helping with expungement and driver's license issues
- Increasing access to education by assisting with school enrollment issues and obtaining services to help children while in school
- Preventing homelessness and increasing access to safe, affordable housing
- Free statewide legal clinics

**Assistance by Legal Aid of West Virginia: Member Quotes**

"I thank God you were involved. Thank you for everything you done! Thank you for the best phone call I've ever received!"

"I just wanted to thank you for all of your help. We couldn't have done it without you."

"I am so grateful for all the help your office provided and especially for Aimee Goddard. She is an amazing person. From the bottom of my heart, thank you, thank you, thank you."

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## Process to identify appropriate levels of support and services

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| CS03 | The Vendor should establish a process by which it will identify appropriate levels of support and services, including, but not limited to: support, placement, and discharge planning services. The Vendor contribution should include identifying appropriate placements, coordination with the caseworker and placement provider on all referrals for placement, and referral follow-up to assist with securing the placement.<br>The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the Child Protective Services (CPS) system in the State. The Vendor should describe how it will assess each case to determine the appropriate level of support and services for the identified and similar scenarios. Vendor referrals needed include, but not limited to, emergency shelter, requests from caseworkers for assistance, children returning from out-of-state, a needed transfer in placement to less restrictive placement, and when a placement is not meeting the child's needs. |

West Virginia CPS investigates reports of child maltreatment and places children in the protective custody of the state when they cannot safely remain in their homes. **Our care coordinators and clinicians support and enhance the critical functions performed by CPS and YS workers** who continue to be inundated with cases over the past several years due to a marked increase of children entering the foster care system. Our efforts to assist CPS and YS have contributed to reductions in residential in-state and out-of-state placements. **Between February 2020 and August 2022, total residential placements decreased by 10.8%.** In-state residential placements decreased by 9.76% and out-of-state residential placements decreased by 25.73%.

High rates of CPS and YS staff turnover compound the increase in cases, which together have increased caseloads for individual workers. Staff turnover leads to fragmentation and delayed decision-making for children. Children are coming in with complex unmet needs and symptoms associated with exposure to toxic stress. **Our care coordinators, embedded onsite at all local DHHR offices throughout West Virginia, have lower turnover rates** allowing us to visit offices at least twice a month to support CPS and YS workers and identify critical support and services. During critical times, our staff visit offices up to two times per week and have **logged 346 office visits so far in 2022.** These efforts provide stability, reduce fragmentation and burden on children and their families, and offer seamless continuity of care.

**Aetna established a detailed process to assist CPS by identifying appropriate levels of support and services for our members**, including support, placement, and discharge planning services, as follows:

- **Child and Adolescent Functional Assessment Scale (CAFAS).** We use the CAFAS tool for all youth in shelter care and residing at in-state residential facilities to evaluate their functioning to help determine the appropriate level of support and services. The CAFAS rater uses multiple sources of information to complete the score, including information provided by the youth, the caregivers, case records, and other informants. The CAFAS is a component of our utilization

**Aetna Better Health Care Coordinator Collaborates with CPS to Prevent Unnecessary Out-of-State Placement**

Anna, a Mountain Health Promise member, has had multiple placements and was recently staying in a hotel with DHHR staff due to no facility or family to take her in. She was frequently denied placement in facilities due to medical issues. She was finally placed at the EYES Shelter at Daniels. Due to miscommunication between DHHR workers about Anna's behavior and medical issues, DHHR recommended that she be moved to an out-of-state placement. Our care coordinator intervened and informed DHHR that Aetna Better Health had recently had a Special Review for Anna to assist with placement options and that information gathered indicated Anna was doing very well with fewer behavioral issues. This information was confirmed at a group meeting requested by our care coordinator with DHHR and the EYES Shelter. Due to the efforts of our care coordinator to collaborate with DHHR and the EYES Shelter about Anna's status and communicate her full story, DHHR was able to find an in-state foster home for Anna to provide her with the patience and structure needed for a successful placement. The DHHR worker stated they would have "never thought a foster placement was an option due to the reports on Anna" and that due to the details facilitated by our care coordinator, they found Anna an in-state, more permanent placement.

management authorization process to identify youth who qualify for services in a community environment. CAFAS scores below 90 indicate that our member qualifies for services in the community while scores above 90 indicate that our member may need more intensive behavioral health services.

> "Family finding is an important tool as we move forward to improving outcomes for our children and youth in WV. No child should have to try and navigate the child welfare system on their own. Connections to the people who love them and whom they love are more important to healing than any "treatment program" could ever be. These connections must be maintained or rediscovered whether they be with biological family members or the child/youth's defined "family." Only when we help our children feel a connection and sense of belonging to their community can we truly see healing."
>
> *– Melody Plumley, MSW, LCSW*
> *Director of Clinical Services*
> *Children's Home Society of WV*

146.WV22

- **Identification of appropriate placement.** If the CAFAS indicates that a child isn't in the appropriate level of care, the care team devotes immediate attention to transition the member to the correct level of care. We share our data, including identified barriers, with the BSS and together we monthly review youth with CAFAS scores less than 90, which indicate community services are appropriate. We refer these youth to our assigned care coordinator who reaches out to the facility and BSS worker to assess progress in treatment and discharge planning, including identifying the barriers that are keeping the youth in the facility when their scores don't indicate a need for that level of care. We work to move that youth into community and family environments through use of family finding and our foster care provider review process. **We've trained over 620 BSS staff on discharge planning.** We also hold Special Review meetings for members experiencing a crisis or unexpected placement disruption, usually within 24 hours of the request, which bring together all key partners to review a child's needs and determine the least restrictive, optimal placement and service array. A level of care is determined based on collected information, including CAFAS scores, current behavior reports, and needs identified by the current placement. We contact all in-state providers who offer the identified level of care. When an appropriate placement cannot be secured in-state, the same process is completed for out-of-state options. If needed, we reach out to our medical director to discuss potential placements.
- **Coordination and follow-up on placements.** Our care coordinator works with placement providers on all referrals to ensure timely placement of youth in the appropriate setting. We ensure that all information is current, accurate, and sent to the requested provider. We contact providers who have yet to render a decision and provide additional information as needed.

To ensure that West Virginia children placed in other states are receiving appropriate treatment, education, and housing, **the Mountain Health Promise executive director and our behavioral health consultant are part of the state's Out-of-State Facility Review Team**, which includes staff from the WV Department of Education, WV Supreme Court, BSS licensing unit, and Kepro Administrative Services Organization (ASO). The team is onsite for three days during each review and evaluates facility compliance with standards for health, nutrition, transportation, and accommodation. Our staff complete clinical chart reviews and meet face-to-face with our members to ensure they receive appropriate evidence-based care by credentialed professionals. We placed quarterly site reviews on hold due to COVID but resumed in February 2022. We've completed three out-of-state facility reviews with a fourth review planned in November 2022.

## Relationships with child welfare workers to improve access to service needs

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| CS04 | The Vendor should establish relationships with child welfare workers, including, but not limited to workers who provide case management, case planning, and permanency planning while the child is in care to coordinate the needs of the child to reduce duplication of services and improve access to service needs.<br>The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the child welfare system in the State. The Vendor should describe how it will structure interactions between child welfare workers, providers, and the Vendor to improve coordination and be efficient and effective. |

Our successful relationships with child welfare workers throughout West Virginia begin with the **foundational partnerships we've established with individuals at the state and regional levels**. We meet at least monthly with the BSS commissioner and the deputy commissioners, weekly with our BSS-assigned liaison, weekly with DHHR leadership, and biweekly with the BSS program managers to develop solutions to address developing needs within specific geographic areas. These ongoing meetings have greatly increased our communication and partnership with the BSS. Most recently, BSS was facing a drastic staffing shortage in the eastern panhandle of WV in Berkeley County. They didn't have the staffing capacity to attend weekly court hearings regarding youth in the foster care system. We agreed to have **our judicial liaison attend the court hearings weekly for 90 days to document the court findings** and share the information with the BSS and our care coordinators.

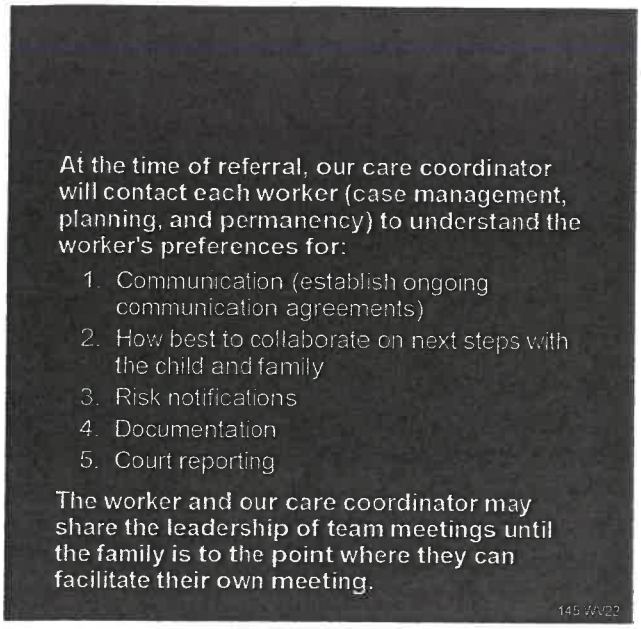
**Aetna Better Health Care Coordinator Collaborates with Youth Services to Successfully Transition Youth Back Home to West Virginia**

Rebecca, a 17-year-old Mountain Health Promise member, was struggling with her gender identity and acting out because she felt unaccepted by her family and community. Due to truancy and other behavioral issues, Rebecca exhausted in state resources and was placed at an out-of-state residential treatment facility for several months. While in treatment, she participated in individual and group therapy sessions and found a medication regime to alleviate her anxiety and depression symptoms. She also participated in family therapy with her adoptive mother to feel more supported in her gender identity and sexual orientation. The Aetna Better Health care coordinator assisted the treatment facility and DHHR in finding LGBTQ+ sensitive providers once Rebecca was discharged home to West Virginia. Rebecca returned to West Virginia in March 2022 and reports that our efforts to locate LGBTQ+ sensitive providers have helped her to make a smooth transition home, including continuing her high school education, and obtaining a part-time job that she loves. Rebecca feels supported and more confident as a member of the LGBTQ+ community and who she is as a person. Her DHHR Youth Services worker reported that it is likely that her case will soon be dismissed since she has made so much progress.

We've structured our interactions with child welfare workers and providers in a manner that coordinates the needs of the child to reduce duplication of services and improve access to service needs. The first critical step in this process is to **establish clear communication protocols** with all individuals involved with the child's case. At the time of referral, our care coordinator will contact the referring worker to understand the worker's perspective, establish ongoing communication agreements, and decide how best to collaborate on next steps with the child and family. There may be more than one worker providing case management, case planning, and permanency planning, and our care coordinator will engage with each worker in support of each phase of care for the child. For many member care teams, a co-facilitation model works well with the social worker and the care coordinator, as they can share the leadership of team meetings until the family is to the point where they can facilitate their own meetings.

Aetna care coordinators and clinicians take on numerous functions for CPS and YS workers to provide support and assistance as their caseloads are ever-increasing. Our care coordinators **work in tandem with CPS and YS social workers** to quickly respond to referrals. We can take over during crises and engage with the youth and parents while activating crisis stabilization and launching the family care team process. Our care coordinators engage with workers and learn their preferences for communication, family care team involvement, risk notifications, documentation, and court reporting,

and tailor their interactions accordingly. We collaborate with workers on court presentations and reports to alleviate a great deal of the worker's mandated responsibilities. Our efforts throughout the child's involvement in the system ensures high-quality care and the accurate reporting out on plans, alternative interventions, risk, and positive outcomes.




On March 1, 2021, we began the process of individualized or **Special Review meetings** held for members experiencing a crisis or unexpected placement disruption. These meetings occur within 24 hours of the request, and we invite all members of the youth's multidisciplinary team. **We completed 116 reviews in 2021 and over 200 reviews from January 1, 2022, through October 2022.** There are a variety of reasons for these reviews, such as: 104 resulted due to losing placement; 52 were in a hotel, DHHR office, or in an emergency room; and 15 were reaching their 18th birthday without a transition plan. Other reasons for Special Review meetings include long lengths of stay at the facility or concerns that the placement isn't meeting the needs of the youth.

CPS investigates reports of child maltreatment and places children in the protective custody of the State of West Virginia when they cannot safely remain in their homes. Court Appointed Special Advocates (CASAs) are community volunteers appointed by local judges to serve as advocates for children who've been removed by CPS. Aetna care coordinators join with CPS and CASAs to conduct monthly **Family Finding orientations for all stakeholders** and **quarterly Family Finding Boot Camps** focused on achieving the following outcomes: increase the number of adult relatives and kin willing to act as a support system for children who've been placed in substitute care, and strengthen collaboration between CASA volunteers and CPS staff to facilitate better case management and service delivery for the children they jointly serve. **A participant from a Family Finding Boot Camp held in March 2022 stated, "Without a doubt, this was one of the best trainings I have attended!"**

**Our care coordinators understand the burden and pressure carried by each CPS worker.** Care coordinators are skilled at explaining this difficult role to youth and families while bridging them back in a constructive way to their worker and the system. The worker may even experience vicarious trauma after a few removals. Our care coordinators practice trauma stewardship daily by supporting CPS workers through their hardships and pain. We take the time to listen to CPS workers describe how difficult their job is and how heart-wrenching the experiences are, as well as the bind they find themselves in when their desire is to help families heal and remain together safely. Our care coordinators provide understanding and validation of the pain and support while also alleviating some of the demands of the workers' jobs.

## Relationships with foster care stakeholders

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| CS07 | The Vendor should establish relationships with applicable State foster care advocacy groups, foster care ombudsman, and Court Appointed Special Advocates (CASAs).<br>The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of State foster care advocacy stakeholders CASAs. |

Aetna has built and maintained robust relationships with state foster care advocacy groups, the foster care ombudsman, and CASAs. We recognize that foster care stakeholders have a desire to make a difference for foster youth and hold a wealth of information needed for the success of Mountain Health Promise. **Our primary focus has been to engage, learn, and collaborate in a manner that fosters deep connections and comprehensive care for youth and families.** Our relationships have allowed us to support and champion large-scale system change statewide to improve the outcomes for foster youth, improve wellness, and reduce the number of children entering the child welfare system. Large-scale change and innovation require in-depth relationships and full engagement with all foster care stakeholders, including collaboration at the state, regional, and local levels.

Aetna continuously engages with foster, adoptive, and kinship families and has demonstrated our desire for honest and transparent communication, including the challenges families face. **We meet biweekly with Director of the WV Foster, Adoptive and Kinship Care Network, Marissa Sanders,** and have worked closely with this organization to learn more about what families need and how the system can better serve youth and families.

We meet at least monthly with the **WV foster care ombudsman** and have developed a very collaborative and supportive relationship. The ombudsman has conducted numerous trainings for our focus groups and is a member of our Governance Council. Our WV CAT has monthly meetings with the entire ombudsman team as we work together to meet the needs of WV children and families.

Our care coordinators **appreciate how important CASAs are in the lives of children involved in the child welfare system**, and we work to include them in the member's care team. The care coordinator makes sure the CASA understands the model of care and how the CASA can contribute to the care plan. The care coordinator bridges the CASA to the family, explaining their role as both a CASA as well as a team member, and dispelling any negative stigma the family may have regarding CASAs. CASAs have served vital roles on the member care team across the country for many years and children in West Virginia benefit from their inclusion on teams and on the training collaborative.

We partnered last summer with WV CASA, Children's Home Society (CHS), Florence Crittenton, Monongalia County Youth Services Center, Board of Child Care, and Dan Martin, the founder of Helping Everyone and Each Other Reach Out™ (HEERO), to offer **HEERO workshops for youth transitioning out of foster care** and into adulthood in several locations across West Virginia. HEERO is a practice approach for transitional-aged youth that recognizes the importance of relationships in overall health and well-being. HEERO youth workshops equip and empower teens with the tools and resources needed to navigate the transition from care to adulthood effectively while still in the safety of care, including building relationships; identifying natural social supports for housing, food security, and employment; and preparing for life without a guardian. HEERO aims to connect people with shared lived experiences and fosters an environment where they can empower one another to reach out to their important people. **Results from the Post-HEERO Youth Workshop Survey found that 90% of participating youth reported feeling confident in their skills to build their own network.**

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## Collaboration with community resources and social services

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| CS08 | The Vendor shall establish relationships and collaborate with the child's community resources to accomplish the following, including, but not limited to facilitating access to services, reducing duplication, and ensuring appropriate placements. The Vendor should establish a process that outlines how they will assist in reducing removals and changes to higher levels of care. The vendor shall include in their submission but not limit it to the following:<br>• Community resources<br>• CPS, PRTFs, residential providers, and behavioral health providers<br>• Key community partners who provide case management, case planning, and permanency planning<br>The Vendor shall provide a detailed description of its approach to meeting this specification. The Vendor shall describe:<br>• Procedures that will be in place for coordination with community resources and social services for members, including those with special health needs<br>• Timeframes for identification of such resources and services |

Our collaborative relationships with a child's community resources facilitate access to services, reduce duplication, and ensure appropriate placements. Through our partnership with community organizations to sponsor HEERO workshops for youth transitioning out of foster care and into adulthood, one youth moved out of a shelter and in with her reunited biological grandmother. Aetna has organized resources to **address social care needs and advance health equity as a mission priority** and deeply embed these resources in our programs and processes. Our procedures and timeframes for identifying and coordinating community resources and social services for members, including those with special health needs, and thereby reduce removals and changes to higher levels of care, are as follows:

- **Identification of Needs.** Throughout the care planning process and ongoing care coordination efforts for all members, including those with special health care needs, our care coordinator and the child's multidisciplinary team identify community resources and social services to address the needs and goals outlined on the member's treatment plan based on their assessments and screenings. **More than three-quarters (76.1%) of Mountain Health Promise members have completed SDoH screenings.**
- **Closed-Loop Referrals.** Aetna's Better Together: SDoH Solutions is a proprietary suite of products and programs aimed at creating healthier members and communities together by addressing social care needs. A key product in our SDoH Solutions is Aetna CVS Health's proprietary Community Resource Directory (CRD), a nationwide directory of community-based organizations and agencies providing services to help address social care needs. **The CRD's database includes nearly 4,792 West Virginia-based resources and 857,000 national resources.** Our care coordinators use the CRD to connect members with community resources to meet their social care needs and follow up to ensure they received the needed resource. This process results in a closed-loop process and timely receipt of community services. Care coordinators follow up within 30 days to close the resource loop for non-emergent needs and 24 hours for emergent needs that could impact the immediate health and safety of the member or their family.
- **Socially Necessary Services (SNS).** We also have a **robust understanding of SNS** and an established contract with a subcontractor to ensure our members receive all needed supports and services to improve family functioning and child outcomes. Our West Virginia team has the expertise required to coordinate Mountain Health Promise member access to these services.
- **Coordination for Members with Special Health Needs.** We conduct collaborative activities with family-centered, community-based systems of coordinated care for children with special health care needs, including early intervention and screening, linkage with parent support groups and forums, and adolescent pregnancy prevention programs. Our CAT works with the Office of Maternal, Child

and Family Health (OMCFH) to improve members' sense of safety, the member experience and access to services, and to reduce barriers to achieving health goals. **Currently, we attend a monthly meeting with the OMCFH to discuss strategies to remove or mitigate service barriers for individual members with special health care needs.**

- **Partnership with CPS.** Aetna has established a detailed process to assist CPS by identifying appropriate levels of support and services for our members, including support, placement, and discharge planning services. **Our care coordinators visit DHHR offices at least twice a month to support CPS and YS workers.** There may be more than one worker providing case management, case planning, and permanency planning, and our care coordinator engages with each worker in support of each phase of care for the child.
- **Relationships with PRTFs, residential providers, and behavioral health providers.** We've **developed innovative strategies to address the staffing challenges facing PRTFs**, including providing incentives to help increase bed capacity at these facilities. We present youth ("Faces to Cases") at monthly meetings with foster care providers and residential providers, as well as contact specific residential networks to locate placement options. Our outreach and collaboration efforts with provider industry stakeholders and associations include monthly Behavioral Healthcare Provider Association meetings where we update providers on any changes in Mountain Health Promise, and advise, discuss, and problem-solve issues raised by members of that association. As we rolled out the CSED waiver, we worked with this association to improve provider understanding and enrollment in this community-based program.

## Engagement with Juvenile Justice System [CS02, CS05, CS06]

A key component of our strategy to ensure the least restrictive placement for youth dually involved in the child welfare and juvenile justice systems is **our judicial liaison who's become a trusted partner to judges and court representatives in local courtrooms throughout West Virginia** and meets weekly with BJS. Our judicial liaison serves as the single point of contact to facilitate direct communication between Aetna and the West Virginia court system. We began our judicial outreach in March 2020 and have **met in-person or virtually with all 78 circuit court judges** to develop partnerships and provide the information they need to best serve children and youth. Our flexibility and expertise allow us to meet the unique needs and requests of each judge and gain their trust.

## Locating appropriate placements

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| CS02 | In compliance with Section 50741 of the Family First Act, states may not enact or advance policies or practices that significantly increase the juvenile justice population. To ensure compliance with this provision, the Vendor shall locate appropriate placements for children dually involved in the child welfare and juvenile justice systems, regardless of Medicaid status.<br>The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the Family First Act and the Child Welfare System in the State. The Vendor will be notified of children dually involved in the child welfare and juvenile justice systems.<br>The Vendor should describe how it will prevent the placement of, whenever possible, and expedite the removal of children inappropriately detained in juvenile justice facilities through this identification and assure the least restrictive placement to meet the child's needs. |

Aetna uses a variety of methods to locate appropriate, least restrictive placements for children dually involved in the child welfare and juvenile justice systems, regardless of Medicaid status. Our judicial liaison collaborates with our care coordinators to engage youth and their families prior to placement and even before transfer to Mountain Health Promise. **We immediately work to prevent children from placement in juvenile justice facilities** upon notification of dually involved children by locating appropriate community placements, as follows:

- **"Faces to Cases."** We present youth ("Faces to Cases") at monthly meetings with foster care providers and contact-specific residential networks to locate placement options.
- **Provider Review Process.** We work to move youth into community and family environments through use of our foster care provider review process.
- **Family Finding.** We use Family Finding to identify placements for youth who have historically struggled to find family-based placements. We host train-the-trainer events to ensure sustainability of the Family Finding model.
- **Special Review.** We hold Special Review meetings for members experiencing a crisis or unexpected placement disruption, usually within 24 hours of the request, which brings together all key partners to review a child's needs and determine the least restrictive, optimal placement and service array.
- **HEERO Workshops.** We partner with foster care stakeholders to offer HEERO workshops for youth transitioning out of foster care and into adulthood in several locations across West Virginia. These workshops help youth create their own network of caring adults to help support them as they transition into adulthood.

**ABHWV Judicial Liaison Facilitates Foster Placement for Youth**

We had a youth in Berkeley County who needed a placement but not residential treatment. Our judicial liaison gathered the youth's information during the court hearing and reached out to our care coordinators to discuss this youth's situation. Our staff contacted foster care providers across the state to find the youth a foster home, which was a significant accomplishment as this was an older youth. The youth is doing very well in this foster placement.

We have a **detailed process to expedite the removal of children that do not meet criteria to be detained** and identify an appropriate next placement. BJS adds the youth's name and circumstances to a list distributed weekly to BSS and Aetna, for youth detained but don't meet criteria to be in a BJS facility. Our judicial liaison, behavioral health liaison, and care coordinators meet weekly with BJS and BSS to discuss these youth and ensure assignment to a care coordinator, that they're at the intensive level of case management, and that supports and services are in place as the youth transitions back into the community. The judicial liaison enters these youth into our QuickBase tracking system to ensure assignment to a care coordinator. Further information gathered in the weekly meeting and our care coordinator contacts with the legal guardian and others, assist with placement. If requested, we perform a Special Review or Provider Review, even prior to enrollment in Mountain Health Promise.

Our care coordinators and Special Review team also **work cooperatively with the Supreme Court of Appeals New View Project**, which reviews youth at risk of lingering in state care who've experienced multiple placements to identify recommendations to assist with permanency. New View field coordinators can outreach the judicial liaison or other Aetna employees for assistance with placement and services. Our team collaborates until we meet the needs of the youth, either via placement or coordination of services.

## Communications with the Judicial System

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| CS05 | The Vendor shall establish communications with the judicial system to help ensure the services ordered for the child are in the child's best interest and medically and socially appropriate. This communication shall include developing, maintaining, and providing a list, at minimum, at the regional level of all services and placement options available to the court. This relationship shall also include being available to provide training and technical services to the court in formal settings, as well as a one-on-one basis to assist in understanding the various treatment and placement options available and how to determine the best option.<br><br>The Vendor shall provide a detailed description of how it will meet this specification. The description shall reflect an understanding of the interactions between the judicial system and child welfare system in the State. The Vendor shall describe how it will collect and maintain the list of placement options available to the court. The Vendor shall also provide information on the training it could provide to court staff on the various levels of services and placement options. Formal training forums could include but are not limited to the court improvement program conferences, judicial stakeholder trainings, and the annual judicial conference as well as pre-recorded materials for court staff to access on-demand. |

Aetna works diligently to communicate with the judicial system at local, regional, and state levels to help ensure ordered services are in the child's best interest and are medically and socially appropriate. At the local level, our care coordinators and judicial liaison work with the BSS and probation officers from the West Virginia Juvenile Division Services to **prepare for and present to the courts individualized care plans and the rationale for the requested services and supports**. Our QuickBase tracking system includes a comprehensive list of all in-state and out-of-state placement options available to the court. We currently evaluate potential placement options for each child and provide that information to the courts using our QuickBase tracking system that includes a drop-down field where we identify an appropriate placement to best meet a given child's needs. We can provide the comprehensive list of placement options to the court upon request.

The judicial system representatives need an opportunity to understand how services will effectively meet a child and family's needs before approval. Together, the Aetna care coordinator and our judicial liaison explain how the services are medically and socially necessary and in the best interest of the child. To ensure court understanding of the various treatment and placement options and how to determine the best option, **we provide training and technical services to the court in formal settings as well as on a one-on-one basis**, including:

- **Training Collaborative.** Court representatives and CASAs participate in courses offered by our training collaborative and can also request individual assistance. We offer training whenever requested for individual groups. We've done training per court jurisdiction and for CASAs regionally, both small and large groups. For example, **we've conducted 152 Family Finding training events throughout West Virginia since March 2020.**
- **Court Hearings and Meetings.** Our judicial liaison attends court hearings and meetings with judges and attorneys to learn about their desires and to provide information on service options and how to coordinate care. Since March 2020, our judicial liaison has **met one-on-one in-person or virtually with all 78 circuit court judges** as well as prosecuting attorneys and probation

### Berkeley County Cases

Our judicial liaison attends all juvenile delinquent and juvenile status cases in Berkeley County for Judge Cohee and Judge Redding to assist BSS with information gathering to ensure the youth involved in these cases have all necessary services and supports. He gathers critical information regarding services and treatment that is either recommended or ordered by the court. This information is tracked on a form we created and then sent to BSS management, BSS staff, and our care coordinators to ensure that referrals are made in a timely manner.

officers to provide information on Mountain Health Promise. **In a recent meeting, a judge told our judicial liaison, "Thank you for your support and information you bring to the court."**

- **Family Treatment Courts.** Our judicial liaison provides information, training, and support at weekly Family Treatment Court meetings in six counties (Boone, Logan, Fayette, Kanawha, Roane, and Calhoun) and is planning involvement with the other eight Family Treatment Courts.

At the state level, we partner with juvenile justice leaders to implement new approaches to care that ultimately drive the reduction of children entering the system as well as a reduction in the current number of open cases. We are working with the BSS and child placement providers to develop alternative foster care models, such as engaging two different foster care providers to serve higher-needs children. **Our judicial liaison is actively involved in several components of the West Virginia Supreme Court of Appeals' Court Improvement Program.** We participate in the program's quarterly board meetings, Youth and Family Services meetings, and judicial stakeholder meetings in individual counties across the state. Through this collaboration, **we've trained more than 100 juvenile probation officers and hosted a Guardian Ad Litem (GAL) Lunch and Learn with 63 GALs attending.**

## Informing the Court of alternative services

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| CS06 | The Vendor shall inform the court of alternative services that best meet the child's needs, as deemed appropriate by the DHHR. This should include, at minimum, providing a written report to the attorney representing the child and the child's case worker in any situation where a child is at risk for a substantial change to their placement needs.<br>The Vendor shall provide a detailed description of how it will meet this specification. The description should reflect an understanding of court orders, how the Vendor's expertise and care coordination can help inform the written report to the attorney representing the child and the child's case worker, and any additional scenarios or services the Vendor could offer the court. A substantial change to placement could include but not limited to placement disruptions, facility discharges, and becoming dually involved in the child welfare and juvenile justice systems. |

Our care coordinators and judicial liaison inform the court of alternative services that best meet the child's needs as deemed appropriate by the DHHR. **We support judges in their courtrooms by providing information on alternative services to improve their decision-making.** We provide information on alternative services at a child's hearing and submit a written report to the attorney representing the child and the child's case worker in any situation where there is risk for a substantial change to their placement needs, such as placement disruptions, facility discharges, and becoming dually involved in the child welfare and juvenile justice systems. We complete a written report for high acuity youth who come through our Special Review process, which includes a list of alternatives with descriptions, data, and the associated outcomes for the individual child and family. We meet with BJS and BSS to develop recommendations for alternative services and placement, included in the report.

We have an extensive understanding of court orders and comply with all court directives, and while we offer recommendations when needed, **we recognize that the court makes the final decision.** Our care coordinators and judicial liaison provide information on needed resources when asked to join a court session, and possible placement options as needed. Our staff provides additional information via email to the DHHR workers and assist with follow-up on any recommended actions. For members who will become a Mountain Health Promise member, we've developed QuickBase tracking that the Care Advocate Team legal staff can access to assist with needs. Court representatives also participate in courses offered by the training collaborative that further explain alternative services and their effectiveness. Our collaborative approach to informing the courts models the collaborative care team model and demonstrates shared accountability and success.

Alternative services are more effective and far less costly for many children and families who are system-involved. An example of an alternative service is the use of peer collaborators to build trust and provide a bridge between the member and formal services, rather than first contact between the worker and the child. Another alternative service is the wraparound planning process and service delivery model that provide intensive services and supports in the home, schools, and communities rather than the more traditional approach of removing children and placing them in residential care or even hospitalization. Effective wraparound has reduced out-of-home placements and hospitalizations across the country. We appreciate the need for the court to have a better understanding of what these alternative services are and how they specifically meet needs as compared to more traditional treatment methodologies.

## Children's mobile crisis response [CS09]

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| CS09 | **The Vendor shall coordinate with the DHHR and any entities determined by the DHHR in developing access, coordination, and training for Children's Mobile Crisis Response (CMCR) services once services are implemented.**<br>**The Vendor shall provide a detailed description of how it will meet this specification** |

Aetna recognizes the critical services provided by the Children's Mobile Crisis Response (CMCR) and Stabilization Teams to help children and young adults going through an emotional or behavioral crisis. These teams offer safety and support during and after the crisis to prevent unnecessary out-of-home placements. Follow-up programs provide resources and skills needed to return members and their families to their normal routines and keep children in their home or current living situation, school, and community whenever possible. **Our care coordinators will use CMCR services as they develop care plans for our members** who are in foster care or kinship care placements as well as the CSED waiver. We'll continue to assist with coordinating these services for families who need this care as CMCR expands throughout West Virginia.


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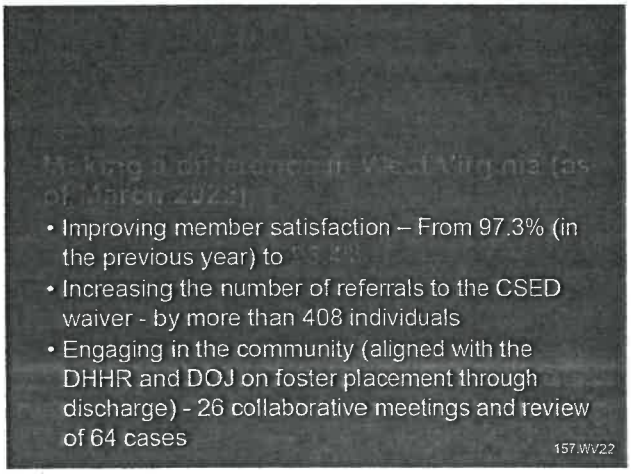
## 4. Member Services

Aetna has shared a three-year relationship with Mountain Health Promise and placed foster children at the forefront of our focus, embedding ourselves within West Virginia communities to provide increased easy access to services. Members need a thorough understanding of benefits and a helping hand to acquire quick and efficient services. **We are the quality leader in West Virginia with a four-star rating from the National Committee for Quality Assurance (NCQA) year-over-year beginning in 2021**, and we demonstrate our statewide commitment to West Virginia members and communities through our superior outcomes, optimal member experience, and support and advancement of statewide goals. We aligned with the Department of Health and Human Resources (DHHR) and the West Virginia Department of Justice (DOJ) Agreement, as well as West Virginia State initiatives and regulations, creating our local, member-centered approach which focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care and socially necessary services (SNS). Our enhanced coordination of care approach minimizes barriers for youth and families, decreasing the burden of accessing treatment by pairing a care connection team member with every member and family resulting in access to services, meaningful and complete electronic health records, improved communication among stakeholders, and reduced fragmentation.

Our knowledge and local member experience in supporting foster children and children and youth involved in the child welfare system offer real-world, community-driven approaches to providing support. Today, we serve approximately 7,839 children in Bureau of Social Services (BSS) custody and 14,289 adopted children. Our SNS population includes 2,255 unique members. **Our Children with Serious Emotional Disorder (CSED) Waiver program has grown to 829 currently active members as of September 2022 and, since its inception, we have served 1,061 approved children.** Our membership has a diverse set of behavioral health, physical health, and social needs, including over 12% with anxiety, 10% with depression, 5.8 with asthma, 3.4% with obesity, 1.1 % with high blood pressure, and 0.5% with tobacco use. Aetna customizes Mountain Health Promise offerings to each community and the community's children, youth, and stakeholders. Deep engagement within the community allows Aetna's member services approach to reflect our ongoing commitment to provide an optimal member service experience, to exceed the needs of the DHHR, members and their families, and local communities.




Our knowledge and experience position us to effectively communicate with members, while we provide outreach and education, to ensure members have access to information and services.

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| MS06 | The Vendor should mail member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, upon assignment to the program, updates to the member handbook and ad hoc handbook requests by a member.<br>The Vendor should provide a proposed format, method of distribution, and, if applicable, the turnaround time for mailing, on an ongoing basis, due to updates to the member handbook and ad hoc handbook requests. |

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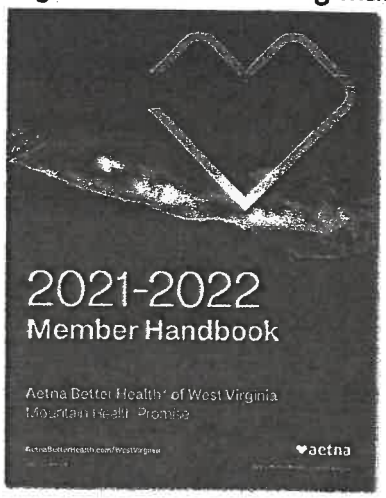
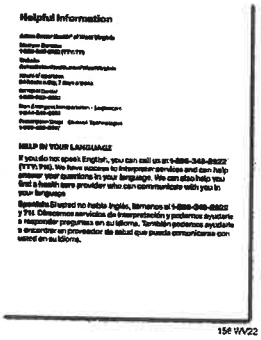
| MS16 | The Vendor should establish and implement a new member enrollment and education process, defined as the time of initial notification of the member's enrollment through the first month of actual enrollment. This process should include, but not limited to, the following:<br>•Member and caregiver contact, including, but not limited to, welcome calls, welcome letters, and/or home visits<br>•Outreach to members and caregivers who are difficult to contact, including, but not limited to, disabled members and members without telephones<br>•Processing and issuing identification cards<br>•Distributing member handbooks<br>The Vendor should describe its new member enrollment and education process, including member contact, from the time of initial notification of the member's enrollment through the first month of actual enrollment. This description should establish the order of steps and associated time frames. |

## Member handbook [MS06, MS16]

Aetna maintains a strong line of communication and partnership with state agencies and community stakeholders and values their input and suggestions from meetings, such as our Mountain Health Promise Governance Council, Member Advisory Council, SNS Focus Group, Residential Treatment Facility (RTF) Group, and Grandfamilies Group, relating to member-informing materials, including the member handbook. Educating members about available services, healthy habits, and participation in their health care is our goal. Our handbook is available in English (98% of West Virginia's population speaks English) and other prevalent languages as determined by the DHHR, or as requested by members. Our Implementation team coordinates with state agencies in adhering to DHHR templates to develop our member handbook, specifically all requirements outlined in the Model Service Provider Agreement. The member handbook also contains a description of member rights and contact information for Member Services (including member advocate), care management, quality management, and grievance and appeals departments. We consider the member handbook to be a living document and review the member handbook at least annually based on member needs and program or policy changes. We submit changes and updates to the DHHR for review and approval, summarizing all changes made since the last review, with a link to the clean current electronic version of the handbook. We request DHHR approval prior to distribution of revisions. Prior revisions approved by the DHHR in the member handbook were specifically designed to meet the health literacy needs of West Virginia children and youth. This youth-friendly handbook offered to children and youth involved in child welfare included easy-to-read and attention-grabbing methods to actively engage younger members to improve their understanding of Aetna's managed care system. Capturing the attention of young people and interesting them in learning about and participating in their health care activities were other goals of the revised member handbook. The development of this revision of the member handbook included using the DHHR-designated template, customized language, and colorful and unique photos appropriate to children and youth at health literacy levels that validate their experiences.




### Distribution of the member handbook

Aetna notifies the new or returning member's household, **within five business days of official enrollment notification** of the availability of our Mountain Health Promise member handbook in

electronic format available on our website; then emails after obtaining the member's agreement to receive the information by email; or auxiliary aids and services upon request at no cost for members with disabilities who cannot access this information online.

We develop our member handbook using DHHR templates in accordance with the Service Provider Agreement. We review our member handbook at least annually and submit updates, along with a summary of all changes, to the Department for review and approval.

Our youth-friendly handbook is easy-to-read and uses attention-grabbing methods to help younger members understand the managed care system and encourage participation in health care activities. The handbook includes a DHHR-designed template and customized language appropriate to children, youth health literacy levels that validate their experiences, and includes colorful, engaging photos. Alternative formats such as audio and video are available upon request, assuring members who have disabilities have opportunities to learn about our services.

We mail member handbooks ad hoc as requested by a member. Members who are blind or have visual impairments may access our member handbook in electronic and audio formats, large print, or braille, or by calling us for information. We notify members at least 14 calendar days in advance of program changes and provide information to access revised member handbooks on our website, by email or request.

## Enrollment, welcome, outreach, and education

We, as the current West Virginia Mountain Health Promise Managed Care Organization (MCO), currently enroll, welcome, outreach, and educate new members in compliance with all contractual requirements. Our process, as described below includes, but not limited to, the following:

- Member and caregiver initial outreach (welcome call or home visit)
- Welcome letter and Welcome packet
- Contact process for hard-to-reach members
- Member identification card and member handbook information

### Member and caregiver initial outreach

Our crisis intervention specialists **conduct initial outreach (welcome call or home visit) within 24 hours** of receiving notification of enrollment. During initial contact we:

- Inquire about urgent health and social care needs and previously scheduled health services
- Assess immediate health and social care needs, connect with services, initiate referrals, and help as needed to meet the member's immediate health and personal needs
- Provide telephone numbers for member services, behavioral health, and health information hotlines, direct contact information, and the address of our website.

**Using Value-Added Services to Improve Quality of Life**

Having experienced much trauma in her young life, Carrie*(name changed to protect member privacy) entered foster care with almost nothing. In addition to making sure she has all the covered services she needs to succeed in life, like new glasses, her Aetna Better Health case manager also helped Carrie get an essential needs duffel bag with toiletry items and a tablet to assist her with homework, provide access to tutoring, and facilitate behavioral telehealth visits. The benefits and services Carrie received greatly boosted her self-esteem and relieved a lot of burden from her foster mother who said without Aetna Better Health's help, "I didn't know how I was going to do it".

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- Demonstrate how to use the website to access information, member handbook, and member information and assist in navigating FamilyConnect
- Advise about our automated outbound call for health risk questionnaire screening and, if necessary, complete it in-person with the member present
- Schedule a health care assessment
- Inform members of their right to continue certain existing services
- Review what to do in an emergency
- Verify primary care provider (PCP) assignment, inquire about their most recent visit, and encourage necessary well-child visits
- Advise of opportunities to learn about our policies and benefits in greater detail




- Confirm that member has access to a complete and up-to-date list of network and SNS providers
- Educate on available value-added services
- Answer questions and provide follow-up as needed to ensure initial contact has been helpful to the member and member's immediate needs are met.

We do not share any protected health information with a caregiver who is not the member's legal guardian without obtaining written permission from the member's legal guardian.

We update the DHHR if the crisis intervention specialist identifies new demographic information during initial contact, to ensure proper recording of demographic updates. We accept addresses for emergency shelters and other non-traditional places of residence. We document all outreach attempts according to DHHR and contractual requirements, including the nature and disposition of those attempts.

### Welcome letter and welcome packet

We customize our member welcome letter and packet to meet the unique needs of West Virginia children, youth, their families, foster parents, and caregivers by providing the following required items and other printed materials deemed appropriate for the region or population served:

- **A welcome letter and packet including information about the member's PCP, the PCP's name, phone number,** and Aetna's member services, other program contacts, and hotline telephone numbers, and a member identification card. Aetna notifies the new or returning member's household within five business days of official enrollment notification of the availability of our Mountain Health Promise member handbook in electronic format available on our website; we provide information how to view the DHHR-approved member handbook on our website, by email, or by verbal request.
- We provide a description of and contact information for the DHHR's Ombudsman program; contact information for the West Virginia enrollment broker; the proximity of emergency care and urgent care facilities; information on how to access non-emergent transportation; education on the importance of the PCP selection; information on how to use different levels of service; and the differences between managed care, fee-for-service care, and having no insurance.
- All member materials are accessible on the Aetna Mountain Health Promise website.

- We inform members they can access DHHR-approved Preferred Drug List (PDL) via our member website and our member handbook. Member services representatives and care management staff help members locate and navigate the PDL on our member website during all points of contact. When requested, we send members a link to the PDL via email.




## Defined contact process for hard-to-reach members

We understand there are many obligations and appointments that occur when our members first come into care or transition between placements. Our flexible outreach efforts, ensure we meet our members where they work, live, and play. We make five attempts to reach foster parents, social workers, or other caregivers at different times on different days. We apply alternate methods for disabled members, those without a telephone, and for difficult to reach members. We demonstrate this by sending mailers in lieu of telephone calls for program enrollment. Inability to reach foster parents, a social worker, or other identified caregivers during our initial outreach, or if a member does not have a telephone, results in us conducting in-person visits in collaboration with system partners, such as community health workers or BSS case workers. We may contact the prescribing pharmacy and request the pharmacy call us when the foster parent or guardian is onsite if we are aware that a hard-to-reach member is being prescribed medication(s). Care coordinators will travel to emergency shelters, hospitals, clinics, and other locations to make initial contact; when we are successful in contacting the member, foster parent, or other caregivers, we ask and document the best way to communicate with them.

## Member identification card

Aetna recognizes that each member in the West Virginia Specialized Managed Care for Children and Youth program is affected by frequent transitions and placements, increasing the likelihood of a lost ID card. Member services representatives educate and inform members of the multiple ways to secure the information on a West Virginia member ID card, including the following:

- View, download, and print member ID card via FamilyConnect
- Reissue replacement ID cards within five days for Mountain Health Promise members when:
  - A member, child welfare staff, caregiver, or foster parent reports a lost card
  - A member has a name change
  - A member, child welfare staff, caregiver, or foster parent requests a new PCP or dental provider
  - The member moves to a new placement
  - Any other reason that results in a change to the information disclosed on the foster care member's ID card

Our Enrollment Department facilitates the processing of ID cards for every member in compliance with Service Provider Agreement timelines. ID cards include the West Virginia name and logo, the member's ID number, the name of the member's PCP, the PCP phone number, and phone numbers for Aetna member services and the 24/7crisis hotlines. We deliver ID cards to members within five business days of receiving the member notification of enrollment. Members can additionally access ID cards upon enrollment by visiting FamilyConnect. Members can request a new ID card by selecting the appropriate option via our member services interactive voice response system or via secure message to member services in FamilyConnect.

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### Tracking enrollment and education compliance

We track all new member outreach attempts and completions to ensure compliance with DHHR requirements, including all telephonic, in-person, mail, and email contact attempts, and review tracking reports against DHHR timelines. We report all members we have contacted or have been unable to contact within the first 30 days of enrollment to the DHHR, along with the nature and disposition of those attempts. We report this data in accordance with DHHR-specific requirements and timeframes.

## [MS09, MS10, MS15, MS14]

| | |
|---|---|
| MS09 | MS09 The Vendor should provide methods for members to contact the member services Agency, including, but not limited to, an emergency hotline and a toll-free number.<br>The Vendor should:<br>1) Describe methods for members to contact the Vendor member services agency<br>2) Describe days and hours of operation<br>3) Describe its member services hotline call transfer protocols and decision trees |
| MS15 | The Vendor should use warm transfer protocols for its member services and other applicable agencies. The Vendor should provide its warm transfer protocols. |
| MS10 | The Vendor should transfer calls between the member services agency and subcontractors for review, if applicable. The Vendor should describe how it will meet this specification. |
| MS14 | The Vendor should use and report to the agency on customer service performance standards, including, but not limited to, the following:<br>•Member-to-representative ratios<br>•Call answering time, with a minimum of 83% of calls answered in 30 seconds<br>•Call abandonment rate not to exceed 5%<br>•Single contact resolution<br>•Turnaround time for member requests<br>The Vendor should describe how it will meet this specification.<br>Note: These reporting requirements may be adjusted by the Agency, as needed, based on the needs of the program. |

## [MS09] Methods of contact and hours of operation

West Virginia's local member services call center is in Charleston, West Virginia, to remain compliant with the Model Service Provider Agreement. **Locally, call center support is available from 8:30 a.m. to 5 p.m. (EST),** Monday through Friday, and on select state holidays. In addition to standard business hours, our centralized call centers, located in Phoenix and Houston, are open **after-hours, thereby providing 24/7 support via one toll-free phone number.** The national team assumes the role of the West Virginia-based member services representatives after business hours. Our member handbook, website, and member welcome materials list the member services toll-free number. Members speak with a well-trained, specialized team that, to the member, provides a seamless redirection of call routing with no interruption and would be no different than service provided during normal business hours. Our national member services staff, trained in West Virginia children and youth program-specific covered services, state, DHHS, BSS, and Child Protective Services (CPS) policies, have access to the same electronic tools used by the West Virginia-based member services team. Members receive the same exemplary service with consistent messaging and information. The national member services representatives have the same access to the health information line (nurse line) and Behavioral Health (BH) Crisis Services hotline for calls requiring clinical support; the member services representative completes a warm transfer of the member so we can address their clinical issues.

### Hotline call routing

Our member services hotline call routing provides timely, accurate responses to member inquiries. **Our The average speed of answer is consistently well below 30 seconds, and year-to-date our average speed of answer is 13.2 seconds.** Members use one telephone number to access our

support. When they call the toll-free member services hotline, our interactive voice response system routes them appropriately by allowing members to choose the department that best meets their needs. Members initially hear an interactive voice prompt welcoming them to Aetna and advising that calls are recorded and monitored for quality assurance purposes. There is a prompt to press option number one to hear the same message in Spanish to connect with a Spanish-speaking representative. The remaining prompts are as follows:

- Press number two if you are experiencing a mental health crisis or are calling about a member who is currently experiencing a crisis
- Press number three if you know your party's extension
- Press number four if you are a member
- Press number five if you are a provider
- Press number nine to repeat these options

Members who speak a non-English prevalent language receive appropriate assistance through member services representatives who immediately engage our language interpreter services for interpretation. If all representatives are currently assisting other members, the system places the member on a brief hold.

Our member services representatives strive for and have resources available for single call resolution supported by our policies and procedures. Representatives use three-way calling, warm transfer protocol, and call escalation procedures to support resolving each member's concern during the initial call. The representative gathers information when a member calls, including the member's name, ID number (if known), date of birth, and the reason for the call. The representative escalates the call to a senior member services representative or supervisor if they are not able to resolve the member's concern by notifying via instant message and completing a warm transfer, including explaining to the member they are seeking assistance to immediately resolve the concern. Member services representatives, trained on techniques such as de-escalation, active listening, and showing empathy, strive to achieve single call resolution, when possible.

## Warm Transfer Capability and Single-call Resolution [MS10, MS15]

**Our telephone management system supports the seamless transfer of calls (three-way and other conference call capabilities) between our member services department and all other departments, including our care management, behavioral health crisis services, and health information hotlines, as well as external numbers, such as SKYGEN for dental and VSP for vision subcontractor services.** Member services representatives also use three-way conference calling functions when assisting members, caregivers, and legal guardians to schedule appointments or connect with community resource agencies (e.g., food banks). During new-hire orientation, we train member services representatives on how to use the telephone management system and practice making three-way calls. The system supports three-way conference calling across all departments such as when hotline staff needs to consult with a member's care coordinator or member advocate. Member services representatives complete a warm transfer when making three-way calls. The representative introduces themselves and the member, for example, and provides a brief explanation of the reason for the call. Representatives stay on the line with the member or caller until the reason for the call is fully addressed, assuring single call resolution and that the member's needs are fully met. Our member service representatives always request a callback number in case of technical difficulty.

Aetna's electronic call documentation system allows for effectively tracking and resolving concerns when single call resolution is not possible. A caller inquiring about a previously reported concern results in the member services representative reviewing the call documentation platform and determines if they can resolve the issue or escalates to a senior or supervisory member services staff. Member services representatives review the call documentation platform daily, assuring they meet all member and caller follow-up needs. The member services director reviews reports of timely resolution and to reassign open records or allocate additional resources, assuring completion of all follow-up calls. Call records also indicate if member services should conduct an outbound call to inform the member of final resolution and close the call when completed.

Our care managers assist with appointments and direct members to community resources. We screen to assess for HCE needs and refer members to appropriate agencies and follow up within in 30 days, and for food and housing, within three to five days.

### Member Services Call Center

Aetna's member services call center staff provides exemplary member service, representing Aetna's core values of inspiration and integrity (doing the right thing for the right reason), excellence (highest quality and value through simple, relevant solutions), and caring (respect through insight, understanding, and compassion). We demonstrate these values through accountability in our existing West Virginia Medicaid call center through hiring and staffing practices, hours of operation, telephone protocols, staff training, and telephone performance. Some examples of our demonstrated values and accountability in our West Virginia member services call center are as follows:

- Respond to all our member needs quickly: For the first three quarters of 2022, we achieved or exceeded all call center goals. The member services call center **exceeded the 83% service level requirement with a total of 2,449 calls answered. The average of calls answered within 30 seconds was 91%. The year-to-date abandonment score was at 0.8%.**
- Support the DHHR's objective for enhanced coordination of care and access to services through our concierge model of member services support by offering immediate, direct linkage to care coordinators, clinicians with behavioral health expertise, nurses, providers, and other medical, dental, behavioral health clinical staff for urgent clinical and crisis support and SNS for SDoH.
- Support the DHHR's objective for enhanced quality of care; minimize barriers for youth and families, reduced fragmentation, and seamless continuity of care; and decrease the burden on accessing treatment by making certain our member services representatives are fully trained in topics customized toward the unique needs of West Virginia foster, adoptive, former foster, and children and youth involved in CPS or West Virginia Department of Corrections and Rehabilitation (WVDOCR) such as the following:
  - Mental health first aid (MHFA)
  - Adverse childhood experiences (ACEs), trauma-informed care (TIC), and West Virginia's trauma transformation learning collaborative
  - Unique needs of West Virginia children and youth involved in foster care, adoption, WVDOCR, and CPS, including the culture of disability and SNS
  - Access to immediate crisis and clinical support
  - Person and family-centered approaches
  - SDoH

- Our national member services department augments our West Virginia call center with the around-the-clock availability that supports the DHHR's objective for seamless continuity of care through after-hours access to our fully trained member services representatives in our 24/7/365 connection to care coordinators and crisis support.

Member service staff, trained in MHFA and TIC, understand the needs of the specialized West Virginia members served in Mountain Health Promise. Our team recognizes that a high percentage of callers may be caregivers or guardians calling on behalf of a child or youth who may be experiencing a crisis and knows how to identify emergencies, urgent social care needs, as well as potentially urgent medical and behavioral health needs, including a crisis of uncontrollable behaviors, an issue in accessing prescribed medication, or notice of disruption. Our team will warm transfer these calls to care coordinators, nurses, and behavioral health clinicians; depending on the identified need our team will warm transfer to 911 emergency services if the caller expresses or describes emergency needs. Our staff, trained to be compassionate during these calls, will continue to engage the caller during the process of messaging the needed managed health care professional clinical team to initiate the warm transfer.

## Member services staffing and performance monitoring [MS14]

Aetna has a dedicated workforce management staff and tools that allow for immediate response to changes in telephone call volume. In the case of an emergency with increased call volume, such as a natural disaster, our business continuity planning includes immediate connection to trained member services representatives from other Medicaid plans. This occurs quickly and seamlessly, as **cross-trained representatives are already skilled, or designated, in our call queues and enterprise telephone system as West Virginia-trained and ready to accept a call.** When call volumes increase, the system automatically routes calls to additional trained representatives in the West Virginia call queue. Aetna also offers high-performing member services representatives the opportunity to work at home. Should localized situations affect the primary office (e.g., flooding, electrical outages, etc.), our work-at-home staff supports business continuity without service interruption.




***Figure: E.4-1 Easy-to-Access Services for Members***
*Aetna's member services representatives support members in many ways, including connecting them to essential services.*

Our workforce management team responds to daily, weekly, monthly, and seasonal trends in call volume. We track and trend performance including service levels, including call answering time, call abandonment rates, and single call resolution. We adjust staffing, accordingly, by anticipating future call volume or forecasting—a quality-driven process that allows us to meet West Virginia children and youth members' needs and consistently exceed the performance standards established by the DHHR. We utilize forecasting data to determine staffing and create schedules with sufficient staff to address member needs and satisfy DHHR performance standards.

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**We have demonstrated our estimated member-to-representative ratio to be 17,944:1. This ratio is based on the volume of member calls and is flexible to meet demand.** Calculation for this ratio includes adding additional representatives to serve the West Virginia Specialized Managed Care Plan for Children and Youth project.

**West Virginia Call Center Data**

| Metric | Goal | 2022 YTD Average |
|---|---|---|
| Average Speed of Answer (ASA) | < 30 seconds | 13.2 |
| Net Promoter Score (NPS) | 81.00% | 88.00% |
| Survey Offer Rate | 40% | 58% |

**As of October, the Ratio of the Member Services Reps to Members is 1:17,944**

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## Call center tracking, monitoring, and performance

Aetna has superior call center monitoring practices that result in exceeding the DHHR call center performance standards. **Aetna has designated quality analysts who complete, at minimum, evaluations of four calls per month per representative**, and documented in the electronic phone recording system. Member services representatives have access to their individual quality audits in the electronic phone recording system and can access the call and feedback from the quality analyst at any time. Senior member services and supervisory staff do a formal review of call audits and feedback and provide coaching, constructive feedback, and kudos to representatives as needed, scheduling one-on-one direct supervision as required. We review calls for service excellence, accuracy of information provided, and adherence to policies via our Net Promoter Score (NPS) program.

We implemented a method to measure the member experience that incentivizes staff toward our Aetna Common Purpose initiative which advocates for members' best health by helping them get the most from their benefits, building trust, and always providing a clear path to care. Our NPS program measures each member's experience through a post-call automated survey that elicits each member's responses to individual calls by asking the caller to rank their recent experience using a scale of one to five, with five being the most satisfied. Member service representatives offer each caller an opportunity to complete this survey at the end of each hotline call. Members complete the brief, automated survey and provide feedback on how likely they are to recommend Aetna to friends and family. We immediately forward any calls ranked with a low score to supervisors who listen to the call and provide coaching. Representatives can promote a positive member experience with use of the automated survey and assure they address member concerns efficiently, effectively, and with service excellence.

We track all member's or authorized representative's calls in the main operating system. Within that system is a call-tracking module. This module automatically assigns the date of documentation and allows for the member services representative to document the full content of the call. Turnaround time of member requests is dependent on the complexity of the request (e.g., ID card 3 – 5 days). [MS14] The member services department documents any resolved case closed for tracking and trending. We document any case not resolved by member services in the grievance and appeal application and the formal grievance or appeal process begins. The call-tracking system is updated with basic information, such as date of decision and the decision of 'overturned', 'upheld,' or 'partially upheld,' upon resolution of the grievance or appeal case. This information allows member services to answer status calls in the event a member calls to check on the status of their case. It also maintains compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations of communicating the minimum amount necessary for member services to do their job. If the member has detailed questions the call is transferred to the grievance and appeal staff member who is processing the case.

## [MS17 – MS18]

| | |
|---|---|
| MS17 | The Vendor should work with the State health exchange during the first six months of the contract to deliver to the Agency an implementation plan for a secure member portal that contains information regarding the program, the member's account, and a portable health passport electronic health record (EHR) for every enrolled member that can be accessed by all caregivers and the appropriate Agency staff.<br>The portable health passport contained in the member portal should include all children's EHR information including, but not limited to, benefit information, medical records, authorization status, and child welfare information of the member. The health passport should align with the Agency for Healthcare Research and Quality (AHRQ) Children's Electronic Health Record (EHR) Format for Children with Special Health Care Needs.<br>Information regarding the AHRQ Children's EHR recommendations and topic areas can be found at the following link:<br>https://ushik.ahrq.gov/mdr/portals/cehrf?system=cehrf<br>Information regarding the American Academy of Pediatrics (AAP) EHR recommendations can be found at the following link:<br>http://publications.aap.org/pediatrics/article-pdf/136/4/e1131/1060310/peds_2015-2655.pdf |
| MS18 | The Vendor should provide a publicly accessible, secure website with information targeted to members that adheres to federal and State marketing regulations. The website should provide information to address the developmental, behavioral, and mental health needs of the members, including but not limited to: information on the Children with a Serious Emotional Disorder waiver (CSEDW), the Mountain Health Promise member handbook, links to community resources, information on healthy habits, information on community group meetings, and information on the Family Resource Network (FRN).<br>The Vendor should describe how it will leverage its website to help meet the needs of members, including the types of information that will be provided. |

## Information technology (IT) solutions that improve access to care [MS17]

Aetna has extensive experience building IT solutions and features to accommodate file exchanges, including admissions, discharges and transfers, community resource referrals, and care plans and related documents from external sources. Cross-domain teams continuously develop and integrate data elements to support member care coordination.

## FamilyConnect: Aetna's EHR and health passport strategy

FamilyConnect serves as our secure member portal. Through FamilyConnect, information regarding the program, member's account, and a portable health passport electronic health record (EHR) for every enrolled member is accessible to authorized DHHR staff. Our industry-leading IT solutions engage members, families, and their circle of support in Aetna's care and services and improves access to care. Enhancements to FamilyConnect 2.0 include access for caregivers, members, and other team members approved by the DHHR. This will include innovative solutions for the health passport, member appeals, member rights and responsibilities, and health education programs. The ongoing collaborative effort with Aetna Better Health IT allows our health plan and state resources, and data from Mountain Health Promise providers available on the HL7 file, to be prioritized and made available in FamilyConnect 2.0. Aetna is also working with the West Virginia Health Information Network (WVHIN) to access WVHIN tools, leverage data feeds to support quality and HEDIS initiative workflows, such as A1c test results for comprehensive diabetes care measurement. Aetna also supports other WVHIN initiatives including participation in our clinical committee and SDoH workgroup (https://www.aetnabetterhealth.com/westvirginia/index.html). Our IT solutions will continue to improve access to care and will include a proprietary EHR customized for the system and member needs of children and youth enrolled in the West Virginia Specialized Managed Care for Youth and Children project. We are and will continue to be compliant with the mandatory requirements for records

retention, West Virginia Office of Technology security policies, and state and federal regulations for websites. Our Internet, intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States code (USC) &794d, and 36 Code of Federal Regulation (CFR) 1194. 21 and 36 CFR 1194. 22.

Aetna has developed a seamless continuity of care solution for members, families, and systemwide partners that reduces fragmentation and is in alignment with designing systems of care identified by the American Academy of Pediatrics guidance for children involved in child welfare. All users can access FamilyConnect through the URL made available on the Aetna Public Website. A FamilyConnect user guide is available to state partners that includes login instructions. **FamilyConnect, Aetna's care coordination application, integrates data from multiple sources once the member is in our system, serving as the single source of comprehensive health records for children and youth, their multidisciplinary teams, and BSS.** FamilyConnect integrates the data from BSS, Families and Children Tracking System (FACTS), emergency department admissions, discharges, treatment feeds, WVHIN systems, and providers. This integration allows for near real-time information-sharing of each member's assessments, care plan, progress, and updates. FamilyConnect promotes seamless continuity of care by authorized interdisciplinary team members who can access to view the most recent member of updates at the point-of-service. Care coordinators have access to FamilyConnect via laptops that accompany the care manager during in-person and in-home visits. Members, their support team, and BSS case workers can view real-time updates, authorization status, and records 24/7/365. Aetna continues to collaborate with the BSS and other state agencies to customize and deliver FamilyConnect to our statewide partners.

Care managers act as the single point of contact on each Care Coordination team as required by DHHR. They document and upload member reassessments, referrals, authorizations, and provider updates. These documents are available through FamilyConnect and **provide a holistic, near real-time view of each member's status and needs.** We update member care plans at least monthly, making certain to monitor and document progress, barriers, and change in needs. We also update the care plan any time there is a change in the member's needs, per member request, per contract requirements, and at minimum, annually. Care coordinators support timely documentation for timely updates of each member's health passport, in accordance with the American Academy of Pediatric guidelines, including chronic health conditions, medications, allergies, psychosocial and family history, trauma history, immunizations, and developmental history. The care coordinator conducts an in-person visit, if there is a significant change, to complete reassessments and ensure referrals and care plan updates are available through FamilyConnect.

West Virginia Mountain Health Promise is the pioneer health plan for FamilyConnect and continues to play a major role in the enhancement of FamilyConnect. Since inception, member security and privacy are of utmost importance. The DHHR and Aetna recognize the importance that the care coordination application adheres to State and federal laws. These laws continue to impact the level of access for both DHHR and the entirety of the member's Care Coordination team to include care givers, group homes, and other providers. FamilyConnect's most recent enhancements include an updated consent feature as well as options for caregiver registration. Successful implementation of the consent process and account registration will rely on the continued partnership with DHHR and the ability to obtain the necessary data elements and authorization forms in a timely manner. Other FamilyConnect enhancements occurred over the past three years which not only support changes in both DHHR and health plan workflow as they relate to access, but also improvements to enhance the user experience.

As we further enhance FamilyConnect for the West Virginia Foster Population, the IT and clinical teams will collaborate with the State and the Health Information Exchange, or any other State-identified agency to ensure the EHR/HL7/AHRQ elements are available for Care Coordination team viewing as appropriate. Some of the data elements that we expect to include:

- Birth information
- Child abuse report
- Child welfare
- Children with special health Care needs
- EPSDT
- Genetic information
- Growth data
- Immunizations
- Medication management
- Newborn screening
- Parent and guardian and family relationship data
- Patient identifier
- Patient portals–PHR
- Prenatal screening
- Primary care management
- Registry linkages
- School-based linkages
- Security and confidentiality
- Specialized scales and scoring
- Well child and preventive care

Aetna is in the process of hiring a FamilyConnect administrator (expected by November 2022). They will reside at the BSS with the primary duty to maintain BSS staff files, ROI adherence and training for BSS staff.

The DHHR has agreed to hire a similar position to support FamilyConnect.

## Publicly accessible, secure website [MS18]

Aetna's publicly accessible secure website (West Virginia Medicaid Plans | Aetna Medicaid West Virginia (aetnabetterhealth.com/West Virginia)) offers a comprehensive resource of easy-to-navigate information critical to the health needs of members. **The website provides members information and addresses developmental, behavioral, and mental health needs, including information for CSED waivers, the Mountain Health Promise member handbook, provider directory, links to community resources and events, and information on healthy habits.** Examples of information found on our website include:

- Resources and tools such as member services contacts, materials and forms, access to the member portal, and a health and wellness library
- Helpful links to help members learn how to apply and choose their plan
- Community resource links, including local resources and services, and news and events
- Information on rights and responsibilities, fraud waste and abuse, and grievances and appeals
- Benefits, covered and value-added services
- Provider search including search filters by specialty, geography, quality, and trauma-certified
- Care management programs including how to access care coordinators
- Important telephone numbers such as member services, behavioral health crisis services hotline, and the health information line
- The member handbook including member rights
- Link and entry to the member's personal medical records, services, and service authorization status

- Health education and prevention information and programs
- Links to the BSS Ombudsman program
- Community resource library including links for WV211, the Family Network Resource libraries, Mountaineer Food Bank, Facing Hunger Foodbank, United Way resources, and women, infant, and children's resources
- Health education topics such as healthy eating and smoking cessation, available in multiple media formats including media, print, and podcasts.
- Member newsletters

Aetna members can access FamilyConnect via the public-facing website. We consult with the BSS to determine who can access the member portal on a case-by-case basis; once determined, members can access comprehensive information about their individual care and view electronic health record and health passport information. Members have access to information related to their care, program(s), and services through easy-to-use functions including menus that offer quick access to each member's health record for frequently requested items such as making a PCP change. Members can access multiple resources in their individual health record including their member ID card, medications, care plan, claims and authorizations, and resources.

### Text messaging

Members can choose to receive text messages customized to their needs based on health conditions, preventive care, or appointment reminders. **Aetna sent 19,288 text messages to Mountain Health Promise enrollees during the month of September 2022, of which 15,092 were received by members.** We inform members of the option to receive text messages from us through our website, contact with member services staff, and information found in the member handbook. An interactive program sends personalized text messages at no cost to inform guardians on the following topics:

- Annual dental visits
- Asthma medication reminders
- Childhood and adolescent immunizations
- Flu vaccines
- Lead screening
- Well-child visits 0 to 13 months, and ages 3 to 21 years

Aetna collaborates with the BSS for our text program vendor to design text campaigns specific to West Virginia Specialized Managed Care for Children and Youth program needs.

## [MS01]

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| MS01 | The Vendor should identify and reach out to members (and their caregiver or caseworker as appropriate) with the most immediate service needs leading up to and immediately following implementation of a program. More information on the risk stratification of members can be found in Appendix 3: Service Provider Agreement.<br>The Vendor should describe how it will meet this specification. |

Described in the care management section, upon receipt of enrollment notification, we immediately outreach to all members and their caregivers or case workers and complete an initial health risk assessment (HRA) to identify members' needs and risk factors to determine an initial care management tier stratification for all members. Members in the Mountain Health Promise program may have, or may be at high risk for, a chronic physical, developmental, behavioral, social, neurological, or emotional condition requiring a broad range of evidence-based primary and specialized medical or behavioral

health, and/or related services. We screen needs in the initial contact with the member and their guardian or circle of support and on an annual basis (or as the member's life or health circumstances change). **The initial screening process includes motivational interviewing techniques and differs slightly based on the youth's circumstances** as described below.

The HRA process allows for initial and immediate member stratification to either tier one population health care coordination, or to additional assessment and determination of referral to tier two (supportive) or tier three (intensive) care coordination based on tier criteria described earlier in this response. All members providing positive responses to any screening question on the HRA, who may have multiple chronic conditions, SDoH barriers, special health care needs, or those who are in foster care, receive further assessment and stratification into the appropriate care coordination level (two or three). The care management staff completes an additional trauma screening questionnaire (TSQ) during the initial screening call for members who stratify to tier two or tier three. Upon completion of the TSQ, the staff identifies and warm transfers the member and their family or guardian to a care coordinator. Members assigned to population health care coordination (Tier 1) receive quarterly calls, as well as educational mailings. Members assigned to a care coordinator for intensive (tier three) or supportive (tier two) care management receive further assessment, care planning, and general care coordination activities as described in the following sections.

While we initially evaluate risk during the HRA screening process to determine a member's preliminary care management tier assignment, we also incorporate our proprietary Consolidated Outreach and Risk Evaluation™ 2.0 (CORE) risk analysis tool as we continue with members in their service delivery journey to reassess risk levels and confirm whether they are still in the appropriate care management tier as their circumstances change. CORE 2.0 identifies members with high health care needs who are the most likely to benefit from tier two or three care management based on two main dimensions of risk:

- Inpatient Admission (IP) risk based on predictive model estimates of the likelihood of the member having an inpatient stay within the next 12 months
- Chronic Illness and Disability Payment System and Medicaid RX (CDPS Rx) score from models that predict future medical cost based on diagnoses and prescribed medications

**CORE 2.0 also includes clinical impact factors, key indicators of health care needs that drive risk and are actionable through care management interventions** (e.g., emergency department risk, comorbidity, medication non-adherence, high prior cost, identified SDoH, and health care utilization).The CORE 2.0 algorithm draws data from medical claims, prescription claims, SDoH, and demographics, and calculates a baseline risk score using the risk percentiles from the CDPS Rx and IP models, then adds additional weights from the clinical impact factors to create a single final score for each member. We stratify members into levels of care management services based on this final score, with a higher score indicating a greater need for higher-tier care management. CORE 2.0 provides more accurate risk-scoring by creating cohorts of members with similar risk profiles grouped by categories of aide and demographics (e.g., children, members with behavioral health needs, members with long term services and support needs, etc.)

## Assignment of MCO care coordination staff, including caseloads by risk stratification and assignment methodology

We assign care coordinators to members based on where the child is located, the complexity of the needs, and whether the care manager has worked with the foster family before, or if there are other children in the home. We ensure sibling groups are with one coordinator, when possible, based on level of acuity.

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## [MS03]

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| MS03 | The Vendor should facilitate connecting members to community resources and social services specific to the member's service area.<br><br>The Vendor should describe how it will connect members to community resources and social services and should demonstrate its understanding of available community resources and social services in the State. The Vendor should indicate how it will identify member needs and the corresponding services and resources in the member's service area. |

Our ability to seamlessly link members and callers to other Aetna departments, crisis support, community resources, and social services specific to a member's service area aspiring to single call resolution—addressing each member's needs the first time they reach out. **Our member services representatives access multiple, comprehensive sources to identify local community resources for members including use of our internal community resource database, collaboration with our care coordinators embedded at local facilities, and collaboration with community health workers and peer support staff.** Our internal community resource directory is web-based and offers search functions by ZIP code and further categorized by food, housing, goods, legal, transportation, health, financial assistance, education, work, and social services. Representatives and care coordinators elicit as much detail as possible from members, identifying need and preferences to connect the member to their preferred and locally accessible resource. Resource information is available nationally for all ZIP codes and updated regularly to reflect the most recent community-based and SNS resources. Members and their families can access the same database via our website. If a member needs food assistance, for example, the member services representative coordinates with Mountaineer Food Bank or Facing Hunger Foodbank or completes a warm transfer and assures connection and assistance by that community resource before ending the call. If members have access to a smartphone or computer, representatives spend time on each call educating members how to navigate local search engines and website resources as needed. Representatives also offer warm transfers to SNS providers for members inquiring about a specifically authorized service.

**Our member services representatives help members or other callers before connecting them to subcontractors, other departments, or community resources including verifying necessary release of information forms for callers who are not the legal guardian.** We handle the first steps of inquiries and questions on behalf of our care coordinators, grievance and appeals, and member advocate staff, allowing for immediate resolution for callers as needed. If a legal guardian calls to request an internal appeal or State Fair Hearing, member services can explain the procedures for both and advise of member rights before linking with the health plan or DHHR program staff. A member or member's family who calls with questions about accessing SNS will have our member services representative determines whether there are any other questions they can answer, such as locating and describing SNS services available to the member, prior to offering a warm transfer, if needed, to a care coordinator. Member services representatives also provide appointment assistance with community resource providers at the member's request. If requested, the representative completes a warm transfer to the provider and assists the member in securing a date and time for a scheduled appointment based on the provider availability and member preferences. Member services representatives are fully trained on SNS and SNS providers, answering questions as indicated. Representatives warm transfer calls to the child or youth's care manager to answer questions about authorized SNS and supports.

**West Virginia 211**

One United Way Square
Charleston, WV 25301
Phone: 1-833-848-9905
wv211.org

2·1·1 West Virginia

United Way

October 20, 2022

Jim Smallridge
Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25302

Dear Jim,

United Way of Central West Virginia and West Virginia 211 are pleased to offer support to Aetna Better Health of West Virginia (ABHWV) for their upcoming resubmission to remain the sole provider of Medicaid services to children and families in foster care and kinship care. ABHWV maintains very high standards of care for this vulnerable population and has successfully provided services for the past 2 years, during one of the most difficult times in our nation's history.

United Way of Central West Virginia supports health and social service programs that have helped thousands of individuals lead healthier and more productive lives. West Virginia 211 provided more than 79,000 referrals to help seekers in 2021, connecting them with resources for everything from rent and utility assistance to food pantries, disaster relief services, and more. We believe that ABHWV shares our passion for helping West Virginia's children and families by providing outstanding health care with valuable added benefits, assistance in navigating the health care system, and meeting people where they are. We know that ABHWV cares about West Virginians because of their level of involvement in all of the communities they serve. They maintain positive relationships with other agencies, participate in community events and meetings, and are knowledgeable about the needs of their members.

We highly recommend Aetna Better Health of West Virginia for the continuation of healthcare management for children and families involved in our state's foster care program.

Sincerely,

Margaret Ann O'Neal
President and Chief Professional Officer
United Way of Central West Virginia

April Knight
State Director
West Virginia 211

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## [MS05]

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| MS05 | The Vendor should conduct outreach and transition planning efforts directed toward members with special healthcare needs including, but not limited to, transition into the Mountain Health Promise program, transitions in placement, and surrounding crisis events.<br>The Vendor should describe how this outreach will be conducted and monitored both at the onset of the program and on an ongoing basis. |

Aetna works with state agencies during the pre-enrollment phase to identify and ensure proper coordination of member care and all transitions to achieve safe transfers.

We consider each member in Mountain Health Promise to have special health care needs. Every member is eligible for care management services and screened and stratified into one of three care management levels that meet their unique, holistic needs. We use our risk stratification model, screenings, clinical assessments, and evaluation of SDoH.

**Through our First in Care Program, our crises intervention specialist begins assisting the member and family, even if the child does not become a foster child but is placed out of their home of origin with family and is enrolled with Aetna.** Our crises intervention specialist outreaches the family, caregiver, or placement to ensure we obtain medical records related to previous medical history and treatment (including vision and dental), as well as immunizations. They also assist the family, caregiver, or placement and state worker in selecting a medical health home and scheduling the member's first medical appointment.

We promptly identify and engage with members who are eligible for the Mountain Health Promise program and utilize a comprehensive suite of screenings, assessments, and risk factor tools to evaluate early life adversities, acute needs, and resilience factors to effectively engage and stratify members into care management. Our care coordination team ensures we connect members and their families in the initial evaluation with the appropriate level of care management and encourage member and family engagement from the beginning.

At times, unique circumstances require more intensive coordination activity. When children, youth, and young adults face possible home removal, placement changes, or are in residential mental health treatment facilities (RMHTFs) or psychiatric residential treatment facilities (PRTFs), our Care Coordination team takes responsive action to mitigate disruption and ensure seamless changes coordination.

We recognize the upheaval caused by home removals or changes in placement and our Care Coordination team, trained in providing responsive support, is well prepared to help throughout these times. During times of significant life changes (e.g., first removal, placement changes, aging out, homelessness, loss of all parents), Care Coordination teams respond to the immediate needs of the situation to foster smooth transitions, through increased communication with caseworkers, and the scheduling of ad hoc care plan reviews. We reevaluate whether the member should receive additional services or care coordination at a higher level than they are at the present time. We immediately act upon any decisions to intensify or add services. We recognize children and youth may experience additional trauma when these life events occur and work to mitigate any additional adverse experiences. .

The Mountain Health Promise project responds quickly to possible placement disruptions and assists with transitions in placement with focus on youth that may be experiencing a placement disruption or are without placement, detained in Bureau of Juvenile Services (BJS), or youth that are in hotels or emergency departments. Upon notification, Aetna schedules a Special Review for the youth, usually

within 24 business hours. This clinical review brings together all the member's team to problem solve and identify the best options for the youth that support their needs and wherever possible their family.

A member detained at a BJS facility is no longer a Mountain Health Promise member; however, with the cooperation of BJS, our care coordination team will continue to monitor the youth weekly with the BJS team. We will assist with discharge planning including securing needed services and support the transition once released from BJS. The BJS or BSS may request if a youth is in BJS and has not been a Mountain Health Promise member prior to detention but with expected custody of BSS at discharge; we may be asked to assist with discharge planning and placement transition prior to the youth becoming a Mountain Health Promise member. At this time, we will begin the process of gathering all necessary information for enrollment and help with service coordination, including the need for a Special Review.

Embedded within the care coordination team, behavioral navigators are involved along the continuum of care and during transitions to differing levels of car to ensure appropriate stabilization.

Aetna is aware once an application is initiated for our CSED waiver and awaits the final eligibility determination. **The Aetna team begins to facilitate the linkage of the family and provider to begin CSED services once eligibility is determined and the family has identified their preferred provider**, ensuring needed clinical services and smooth transition occurs.

We will also assist with the IDD waiver process for youth that may have intellectual challenges. We will assist with service recommendations and with a warm hand-off to the to the Medicaid fee-for-service IDD waiver programs.

## Outreach at the onset of the program and on an ongoing basis

**At the onset**, foster children identified for Mountain Health Promise receive screening and assessments performed by care management staff to assess for appropriate level of care. Once identified as needing transition to placement, and based on the level of care, the care manager engages procedures for placement. We assign Level 3, PRTF, and shelter placements to a case manager. A care manager receives Level 1 or 2 members. If a child experiences a crisis event, staff will notify the appropriate parties (e.g., DHHR, care manager, ask for a Special Review to provide options for treatments, explore intervention options).

**For any ongoing level of placement**, case management staff will reach out at least weekly (but more often if the need for stabilization presents). More frequent contact with members in crisis allows our staff to ensure all involved (e.g., facilities) have up-to-date communication of the member's status, including ongoing assessment and documentation per intensity level requirements. Stabilized members discharged to a stable setting may transition to a lower level of support and are always followed, for at least 30 days, by a care manager before moving to lower or higher levels of care.

## [MS02]

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| MS02 | The Vendor should provide outreach and training on an ongoing basis to youth and young adults and their respective caregivers who are eligible for services. The Vendor should collaborate with community partners to help design materials for a community resource library including, but not limited to, member handbooks, newsletters, and/or directed educational materials that best meet the needs of the populations being served in accordance with federal and State marketing regulations. Information on how to access these materials should be provided to members upon initial enrollment.<br>The Vendor should describe the audience(s), frequency, method(s), and topic(s) for this outreach and training |

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## Outreach and training to eligible youth, young adults, and caregivers

The designated health plan staff includes Care Advocate teams who oversee the children's systems, adult system, the juvenile justice system, recovery and resiliency administrator, and our adoptive parent liaison. This Care Advocate team uses feedback from our focus groups for members and families with special health care needs, satisfaction surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) that elicit feedback about children with chronic or behavioral health conditions from both members and providers, and utilization data to inform our policies, outreach, and training strategies, and to facilitate discussion in monthly and ongoing forums with State agencies.

Our governance approach and existing West Virginia community outreach efforts inform our outreach and training strategies for eligible children, youth, and caregivers. We educate eligible children, youth, and caregivers about Medicaid enrollment and services and connect them, if necessary, to appropriate managed care or community and social resources. We develop our materials with our eligible target audience in mind and include easy-to-understand language and pictures, such as our wellness activity coloring book for children. We identify appropriate topics for our community events and training based on the needs of the members we serve and customize them based on regionally specific needs. **Our Care Advocate team and Community Outreach teams collaborate with the BSS and providers to identify the most appropriate strategies including frequency and audience(s) for targeted, regionally specific outreach and training.**

Members and caregivers receive a copy of our member handbook at time of enrollment, upon request, and receive information on where the member handbook is located on our website.

Aetna provides a continuous program of general health education for disease and injury prevention in various formats that may include brochures, newsletters, videos, magazines, presentations, and classroom instruction available on the website, regular mail, email, or text messages. We use the language line, TTY, alternative member materials in different formats so members with disabilities have equal access to educational materials.

Throughout the care planning process and ongoing care coordination efforts for all members (including those with special health care needs), the care coordinator and interdisciplinary care team (ICT) identify community resources and social services that may address the SDoH needs or goals outlined in the member's treatment plan. These needs are re-evaluated at the reassessment and care plan update intervals described earlier in this response. When we identify a particular community resource or social service as a need, the ICT establishes in the care plan and the date when services must be obtained, depending on the urgency for the individual member. **The care coordinator uses our Community Resource Directory and leverages our relationships with community partners to link members and their families to the appropriate services in their region.** For members with urgent social service needs, we follow up within 24 hours to ensure they were able to access the needed service. For non-urgent needs, we follow up within 30 days.

Examples of the types of community services we refer members to include West Virginia's foster care Clothing Closet, Red Barn Stables (equine therapy), Safe Haven (foster parent support group), and JobCorps.

## [MS04]

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| MS04 | The Vendor should use a methodology, including, but not limited to, claims history and proximity, to assign members to a primary care provider (PCP), notify the member of the right to change PCPs, and conduct follow-up communications to ensure members eligible for medical services are aware of their PCP assignment. |

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| | The Vendor should describe in detail its proposed methodology for making primary care provider (PCP assignments, particularly for new members when auto-assigning to a PCP. |

## PCP assignment and outreach

Aetna recognizes our new members' right to maintain PCP and specialists already involved with the child, youth, or family. We have developed an enrollment and PCP assignment workflow to support this, and other unique needs of children and youth enrolled in the Specialized Managed Care for Children and Youth program. If a new member does not select a PCP with the DHHR at the time of initial enrollment, **we use our comprehensive rules-based PCP assignment application to assign a PCP.** This application applies rules based on the member's existing PCP relationship (if known), location/proximity, claims history, language needs, and cultural needs. The system also assists with auto-assignment.

Assignments are based on where the member's child welfare staff case is located (which is usually the Medicaid region where the child's family of origin resides). The member is auto-assigned to their current PCP, if no PCP is identified. If the member does not have a currently assigned PCP, the CPS case worker, caregiver, or foster parent can voluntarily select a PCP. Alternatively, Aetna may auto-assign the member a PCP within two business days of receipt of notification of the member's enrollment in the program using claims history, proximity, and specific system logic containing the DHHR's guidelines and our priority providers. Where appropriate we will enable geographical assignment of members to providers with higher quality scores to enhance member satisfaction and quality of care.

**We inform members and caregivers during the initial care management contact, and they receive a welcome letter in the welcome kit that includes PCP assignment information.** Because the member/PCP relationship is critical to successful treatment and coordination of care, our care coordinator and member services staff work with members to make sure we prioritize their preferred choices. Members are informed about their right member to change PCP in our welcome packet and the member handbook and as applicable per calls to our services hotline or during telephonic or in-person visits with the member's care coordinator. **Aetna's care coordinator conducts follow-up communication with new members/guardians/system stakeholders to inform them and verify their PCP assignment and will assist in making changes as needed.** Care coordinators identify and assist in appointment scheduling and complete follow-up calls to assure attendance.

We have established policies and procedures to support ongoing monitoring PCP panels for compliance the Service Provider Agreement Section 3, including the BMS limit of 2,000 Medicaid members assigned per PCP, for applicable populations.

We currently have 100 percent of members with access to a PCP within the time and distance standards. We have 99 percent coverage across West Virginia. **We currently contract with over 3,000 PCPs, including over 500 pediatricians, and over 97% of PCP network has open and accessible panels for new members.**

## [MS11]

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| MS11 | The Vendor should educate member services representatives on the out-of-network referral process and carved out services such as Non-Emergency Transportation (NEMT) and pharmacy. |

## Out-of-network referral education

Our member services call center representatives receive in-depth, interactive training on the navigation of our provider network searches, member website resources, out-of-network referral process, and carved-out services, as part of our new hire and annual training. We audit our member services staff

monthly and provide ongoing training to ensure the proficiency of our representatives. In addition, member services are knowledgeable on the process of obtaining services from providers who are not currently participating with the health plan.

Aetna educates member services call center representatives and members about their ability to request out-of-network referrals and the out-of-network referral process, NEMT and pharmacy through individual calls to our member services call center or care manager. We outline the out-of-network referral process in our member handbook, which is available on the Aetna website and member portal. This includes education about our network, member's rights to choose out-of-network providers including keeping existing providers or specialists, and member responsibility for out-of-network provider choices.

**The out-of-network referral process is described in greater detail in response to Attachment E – Care Management. [CM05, CM26]**

## [MS12, MS13]

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| MS12 | The Vendor should train member services representatives on topics including, but not limited to, serving members with disabilities and chronic conditions, the culture of disability, the foster care system, mental and behavioral challenges of the population, adverse childhood experiences (ACEs), and resources available to members. |
| MS13 | The Vendor should, on an ongoing basis and at a set frequency, provide training to staff who perform outreach to members with special healthcare needs upon the member's enrollment.<br>The Vendor should describe how it will meet this specification, including, but not limited to, proposed training frequency and curriculum. The Vendor should describe how it will meet this specification, including, but not limited to, proposed training frequency and curriculum. |

## Member services training [MS12 and MS13]

Aetna leverages our national training expertise and local experience to incorporate the needs of West Virginia members into our four-week comprehensive training and review processes for member services staff. **Member services staff, including our member advocate, complete four weeks of classroom, online, and interactive training during new-hire initial training followed up by an additional three months of coaching and feedback.** We accommodate diverse learning styles by using multiple training modalities. The staff practice responding to scenarios that focus on concerns they are likely to receive from West Virginia members. Initial training includes direct oversight of their performance through job shadowing and observation with a preceptor before they have contact with members. Preceptors demonstrate how to handle calls/emails, how to operate the telephone, email, and documentation system, how to navigate resources, and best practices for resolving a member's concerns. After observing the preceptor, the representative takes calls with the preceptor observing and coaching on live calls and emails. We reinforce training through monthly call/email audits that include review of topics such as greeting, identification, telephone etiquette, call servicing, documentation, and West Virginia program requirements. Supervisor's complete audits, review scores, and identify areas for improvement with staff monthly or more frequently, depending on need.

Aetna uses multiple, **ongoing training approaches to reinforce content learned:** staff sign acknowledgement of understanding forms; daily debriefs between the supervisor and representative; training by the senior representatives during bimonthly staff meetings; quarterly training on quality initiatives such as documentation and exemplary member experience practices; on-the-spot, real-time support from senior representatives through chat and instant messaging; annual classroom training; and online webinars. We review and update training curriculum annually or as programs change to follow DHHR requirements, State and federal laws, and West Virginia regulations. We update and

provide additional trainings as needed when we have new systems that require navigation or as modifications to West Virginia programs occur. We incorporate feedback gathered from automated surveys, quality satisfaction surveys, and Member Advisory Committees into our training curriculum. Representatives receive training reminders and have access to e-learning tools (e. g., online, self-paced training modules, search engines, desktop references and guides, and written training materials). Aetna addresses training for member services during new-hire onboarding, monthly department trainings and annual refresher trainings on items such as serving members with disabilities and chronic conditions, the culture of disability, the foster care system, mental and behavioral challenges of the population, ACEs, resources available to members, code of conduct, HIPAA, protected health information (PHI), fraud, waste, and abuse, and record retention.

| Training Topic | Training Curriculum Description | Training Timeline/Frequency |
|---|---|---|
| **Covered and Value-added Services** | Overview of covered services including physical, behavioral, SNS, and dental services, preventive services, role of the PCP and assignments, how to access services, how to provide appointment scheduling assistance, out-of-network services, limitations, and medical necessity; the member handbook; member grievance and appeals; Aetna's value-added services and related benefits | New-hire initial training and as program changes occur; monthly training on BH services; current staff upon program implementation |
| **West Virginia Requirements** | Overview of Managed Care Plan for Children and Youth program and related requirements including member rights, member grievance and appeals, and advance directives; unique needs for foster, adoptive, and children and youth involved in CPS; unique needs of children and youth involved in juvenile justice/WVDOCR; regional and service area distinctions | New-hire initial training, as program changes occur, current staff upon program implementation |
| **Enabling Services and Cultural Competency** | Overview of enabling services, federal regulations, and DHHR requirements; overview of cultural competency including Aetna values, ethics, diversity, health care equity, disparities, health literacy, regulatory requirements, language differences, National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, Children and Youth program unique needs, interpretation services, use of teletypewriter, culture of disability, disabilities and chronic conditions, and disability accommodations Striving for Health Equity in all interactions | New-hire initial training, annually |
| **Assisting Members with Limited English Proficiency** | Overview of West Virginia population, engaging members with limited English proficiency, and instructions on how to access 24/7/365 subcontracted interpreter services | New-hire initial training |
| **Assisting Members in Locating Providers and Community Resources** | Review of member handbook, instructions on how to navigate Aetna's care management provider search portal, website provider search function, and mobile application; overview and navigation instruction for community resource databases including Family Resource Network, CarePortal, Aetna's internal database and local community resources available to members | New-hire initial training |
| **Service Excellence** | Overview of Aetna service excellence standards, call center conduct and expectations, soft skills, use of phone, instant messaging, website, and internal databases and systems, problem-solving, taking and responding to complaints | New-hire initial training |

| Training Topic | Training Curriculum Description | Training Timeline/Frequency |
|---|---|---|
| **How to Manage Crisis and Clinical Calls** | Overview of Health Information line and BH Crisis Services hotline; review of procedures for when and how to refer; instructions on how to access both; warm transfer and escalation protocols; how to inquire about life-threatening illnesses; how to access 911 and emergency services; triggers for medical or BH crises; warm transfer and escalation protocols; using principles identified in MHFA and TIC with callers | New-hire initial training |
| **Members with Special Health Care Needs** | Overview of members with special health care needs, outreach and transition planning, members with chronic conditions, MHFA, and TIC | New-hire initial training, as program changes occur |
| **Privacy and HIPAA** | Overview of HIPAA, privacy regulations, appropriate use of sharing information, State and federal laws, member rights and protection, Medicaid requirements, confidentiality, ethical code, HIPAA safeguards and compliance, and preventing fraud, waste, and abuse | New-hire initial training, annually |
| **Abuse, Neglect, and Exploitation (ANE)** | Description of State mandated reporting requirements, policies, and required forms | New-hire initial training, annually |
| **Member Advocacy** | Overview of member advocate role and responsibilities, complaint and internal appeal process, and State Fair Hearing process | New-hire initial training, as program changes occur |

## Health Care Staff Training

Staff who perform outreach to members, including those members with special health care needs, receive new-hire training, monthly department trainings, and annual refresher training. Comprehensive training such as ACEs, TIC techniques due to the high prevalence of adverse life events, as well as training on culturally responsive care that ensure a personalize, responsive approach to the unique needs of each member. Training topics include MHFA, ACEs, TIC, ongoing BH training via Relias Learning Management System, technology-based training via Aetna Learning and Performance Center, and any other State-specific training. Aetna designates time off the phone for representatives to complete scheduled training. Primarily intended for adults, the MHFA training course shares information on how to help young people experiencing mental health challenges. It reviews the unique risk factors and warning signs of mental health problems in adolescents ages 12-18 and emphasizes the importance of early intervention. The program is managed, operated, and disseminated by the Nation Council for Mental Wellbeing.

## [MS07, MS08]

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| MS07 | The Vendor should provide enabling services—including, but not limited to, assistance with complaints, grievances, and appeals—to members with physical or developmental disabilities.<br>The Vendor should consult with persons with disabilities and advocacy groups while developing materials for members with special healthcare needs.<br>The Vendor should describe how it will meet this specification. |
| MS08 | The Vendor should ensure the Contract Liaison/Medicaid Administrator monitors grievances and appeals—including, but not limited to, grievances related to subcontractors—for enabling services for members with physical or developmental disabilities. The Vendor should also track grievances and appeals for trends, gaps in care, and systemic issues in the program and create a plan to address them.<br>The Vendor should describe how it will meet this specification, including the process for tracking and addressing identified issues. |

## Enabling Services [MS07]

Aetna provides enabling services to members to address barriers to access to care and services, and social determinants of health. Enabling services are designed to reduce health disparities in adherences to all language, information, and accessibility requirements outlined in the Title III Americans with Disabilities Act (ADA). **Enabling services include the availability of translation and interpreter services, health care coordination, health education, transportation, assistance with benefits, complaints, grievances, and appeals, and access to SDoH to members with physical or developmental disabilities.**

We aim to hire bilingual and multilingual staff that are fluent in West Virginia's most prevalent non-English languages, based on DHHR data and state needs. Aetna provides members with a wide range of language services and accommodations for limited English proficiency and special needs including the following:

- Informing members of their right to language assistance for in-person visits, telephone calls, and in written materials at every point of contact, including calls to the member services call center, member materials including complaint, grievance and appeal materials, signs in facilities and provider offices, other in-person meetings, and telephone communications
- Training all staff and providers to identify and respond to a member's need for language or other enabling services
- Supplying, at no cost, translation and interpreter services through our member services representatives who are certified translators as well as vendors who employ Certified Medical Interpreters
- Reviewing language assistance vendor activity reports and conducting assessments of member language preferences and service quality
- Consulting with persons with disabilities and advocacy groups while developing materials for members with special health care needs

### Consulting and developing materials for special health care needs

Aetna collaborates with several state and community organizations such as the DHHR, juvenile justice (JJ) system, Court Appointed Special Advocates (CASA), provider network, homeless shelters, community centers, service agencies, domestic violence centers, and school systems to create assessments, care plans, and **informing materials, such as member handbooks, to meet the special needs of members in foster care.** For example:

- In 2019, Aetna developed a relationship with the foster care advocacy group, Family Finding, and enlisted the direct assistance of its founder, Kevin Campbell, to implement this approach for West Virginia children in foster care. Our goal, at Aetna, is to assist West Virginia foster children with a permanency plan that includes lifelong and informal relationships in the member's circle of support.
- We also use the LifeCourse Framework, originally created for persons with disabilities, to assist members to identify goals for their current and future life with or without disabilities.

Our Care Coordination team provides care management services and is made up of Clinical Case Managers (CCM), Case Management Coordinators (CMC), and Case Management Associates (CMA). The Care Coordination team uses several models woven throughout our care planning and coordination processes for children in foster care, adoption assistance, and those with special health care needs. Using the tools within our trauma-informed care framework, the Care Coordination team works closely consulting with members and their families to identify key life stages and provide

thoughtful anticipatory guidance and resources related to major milestones to sustain members' quality of life, avoid unnecessary transitions, ensure continuity of care, and achieve permanency.

## Member services call center support

Aetna provides member services **inbound call center support 24 hours a day, 7 days a week. Member services representatives are readily available to receive, capture, and disposition verbal complaints, grievances, and appeals from members and providers. Member services routes all instances of dissatisfaction expeditiously and in accordance to established turnaround times.** Our member services department immediately connects members with translation and language interpretation at no-cost interpretation to members in over 200 languages. Our member services representatives are fully trained in and utilize West Virginia Relay Services for members who are deaf or hard of hearing. The first time a member calls our member services hotline and requests an interpreter, we enter a memo on the member's record in our electronic care/claims management system, so all department members are aware the member requires language assistance. The memo notes the language needed and the services we provided.

Aetna places high value on appropriately educating members on their health care and their rights as members through quality customer service. Our member services, care management, and member advocate staff, trained and prepared to assist members with special health care needs telephonically, in-person, or via written communication, include the use of and connection to enabling services. We educate members about the grievance and appeal system and their right to file a grievance or appeal about any aspect of their care or service, including, but not limited to, physical health, behavioral health, prescription drugs, and community engagement. We educate members about the grievance and appeal system, along with any changes through written materials (e.g., member welcome packet, handbook, website, and letters). Additionally, we provide written materials to all our subcontractors, at the time of contract and whenever changes occur, so they can effectively support and assist members with filing a grievance or appeal. Member education materials, written at a sixth grade reading level or less, include the following:

- Information in English and other prevalent languages, as well as in alternative formats (e.g., interpreter services, translation services, audio tapes, sign language, large font, and teletypewriter [TTY] through Relay West Virginia). We also make other reasonable accommodations available to all members and have accessible meeting spaces for members with physical disabilities who wish to file a grievance or appeal, or present information, or otherwise participate in person, at no cost to the member.
- Procedures for filing a grievance, appeal, and/or State Fair Hearing
- Right to representation (e.g., self, family member, attorney, relative, friend, or provider)
- Information on how to access the Managed Care and/or DHHR Ombudsman's office
- Requirement that internal appeals must be exhausted before requesting a State Fair Hear Procedures for exercising rights to request a State Fair Hearing within a specified timeframe
- Requirement that internal appeals must be exhausted before requesting a State Fair Hearing
- Right to continue benefits at the current level of appeal requested within the specified timeframe
- Communication that the member may be required to pay the cost of services furnished if the final decision is an adverse decision to the member.

Our member grievance and appeal processes afford members the opportunity to voice their issues, concerns, and problems with the assurance that there is no discrimination based solely on their filing a

grievance or appeal. **We resolve grievances and appeals in a timely manner in accordance with West Virginia defined timeframes and help to ensure that all members regardless of disability or background receive equitable and effective treatment in a culturally and linguistically appropriate manner.** We make sure that no punitive action is taken against members, their authorized representatives, or providers who support them for filing a grievance, appeal, or State Fair Hearing.

Whenever needed, our member advocate assists members in completing forms and navigating all procedural steps, from filing a grievance or appeal through a State Fair Hearing, if requested.

### Notice of adverse benefit determination

Care coordinators, our member advocate, and member services staff can assist members in understanding and following guidance provided in our notice of action determinations. Our notice of action process provides for a written notice of action to members or their designated representative in accordance with West Virginia statutes. The notice of action is written in easily understandable language and explains the adverse benefit decision.

### Filing and Resolving a Grievance or Appeal

Our published member communication materials inform members how to designate a representative, to act on the member's behalf, at any time during the grievance and appeal process. To verify the authority of designated representatives, Aetna requires authorization to be in writing and signed by the member, unless the person is a legally designated representative (e.g., parent, guardian, and conservator). Members or their authorized representative have the right to examine the member's case file, including medical records and any other documents and records considered during the grievance and appeal process, and may request copies of all documents free of charge. They may also present supporting documentation or evidence by phone, in person, or in writing on or before the date of the grievance or appeal meeting date. To present information, the member or their authorized representative should contact the Grievance and Appeal department. The parties to the grievance or appeal include the health plan, the member, and their representative or the representative of a deceased member's estate.

Members, their authorized representatives, including legal representatives of a member's estate may file a grievance or appeal in person, by telephone, fax, voicemail, email, through the website, or in writing. We assist members in filing grievances and appeals, if requested or if we identify a need. Member assistance may include auxiliary aids and services, such as interpreter services and numbers that have adequate TTY-TTD and interpreter capability. Upon receipt of a member grievance or appeal, our grievance and appeal team documents in the appeal and grievance application the concern and assigns it for review. A grievance and appeal coordinator reviews all the facts to determine whether the case should be processed as a grievance or appeal, and whether it should be expedited.

When a member or their designated representative requests the review of an action where we denied, reduced, suspended, or terminated an item or service (typically through a notice of adverse benefit determination), we review the request in accordance with our member appeal process. When a member or their designated representative demonstrates dissatisfaction with services or other concerns unrelated to an appeal, the review is conducted in accordance with our member grievance process. When the grievance is about the service or care they received from a provider, we always secure member permission to utilize their name to investigate the grievance. Grievances may be filed at any time; appeals must be filed within 60 calendar days of the initial denial. If we identify a potential quality of care issue, we engage with our Quality Management department for review and investigation, and simultaneously continue with the grievance process.

Any member may continue to receive services during the appeal or the State Fair Hearing process for an ongoing course of treatment that was previously approved that is being reduced, denied, termed, or suspended as long as the request is filed timely. The timeframe to file for continuation of benefits at the current level during the appeals process is within 13 calendar days from the health plan mailing the notice of action and the intended effective date of the health plan's proposed adverse benefit determination.

### Verbal and written notification

Aetna member services and member advocate staff provide members with any assistance needed including enabling services if the member would like to submit a written grievance or appeal.

Aetna resolves and sends a written notice for all standard written grievances and all appeals as expeditiously as the member's health condition requires, but in no case exceeds 72 hours for expedited grievances and appeals or 30 days from receipt for standard written appeals, unless there is an extension, and 90 days for grievances and complaints. For expedited cases we attempt to provide verbal notice of a decision followed in writing within the 72-hour timeframe. When we reach a decision prior to the 30-calendar day timeline for standard cases, our staff is required to send written notification within 3 calendar days of the decision, to avoid undue delays in responding to members.

### Member State Fair Hearing process

After exhausting the internal appeal process, the member or their authorized representative may request a State Fair Hearing within 120 calendar days from the appeal decision letter. Our member advocate is assigned to all State Fair Hearing cases, assuring necessary enabling services and member understanding each step of the way. The request may be made in person, by telephone, voicemail, email, through the website, or in writing. The State Fair Hearing process provides members with an opportunity for a State Fair Hearing before an impartial hearing officer. The parties to the State Fair Hearing include the health plan, the member, and their authorized representative, including a provider, or the representative of a deceased member's estate, or a foster care member over age 18 designated representative.

When a State Fair Hearing has been requested, Aetna provides information regarding whether an appeal has been filed, the date the appeal was filed, and the resolution of the appeal. This information is provided within one working day of receiving the request from the State Fair Hearing Office. If the request for State Fair Hearing regarding a standard appeal is received by Aetna, we forward the case file to the DHHR within the state-required timeframe. If the hearing officer reverses our decision to deny, limit, or delay services that were not furnished while the State Fair Hearing was pending, we promptly authorize or provide the disputed services, and as expeditiously as our member's health condition requires, but no later than 72 hours from the date we receive the notice from the State Fair Hearing reversing the decision.

### Expedited review process

Upon receipt of an expedited verbal or written appeal, a clinical reviewer immediately reviews the case to assess the urgency of the issue being appealed to the member's current health condition, to determine whether the issue meets the criteria for expedited processing. If the issue fails to meet the expedited appeal criteria, we transfer it to the standard appeal process and maintain the original received date and notify the member verbally within 24 hours of the transfer and send written notification within 2 calendar days. The notification informs the member that they may file a grievance if they disagree with our decision to transfer the case to the standard review timeframe.

Grievances are processed in an expedited timeframe whenever the grievance is the result of the denial of expedited processing of a prior authorization request or an appeal, or when Aetna takes an extension on the processing of a prior authorization request or an appeal. Appeals are processed in an expedited timeframe whenever the item/service being appealed is pre-service, the provider requests expedited processing, the provider supports the member's request for expedited processing, or anytime it is determined that waiting the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Neither written confirmation nor the member's written consent is required for the provider to act on the member's behalf to request an expedited appeal.

When processing an expedited grievance or appeal, Aetna complies with all required criteria related to the resolution of the issue, as described previously in the standard appeal process, including the review of all records and information without regard to whether the information was considered in the initial adverse benefit determination, and that the case is decided by an appropriate decision-maker. Members and their representatives are also advised of their rights, as described in the standard appeal process description, including the limited time to present evidence and information, and the right to receive a copy of the case file at no cost. Aetna resolves expedited grievances and expedited appeals within 72 hours of receipt. We attempt to provide verbal notification followed by written notification within 72 hours. Our written notice includes all required information, including information on how to request an expedited State Fair Hearing, if the decision is averse to the member. Upon resolution of the expedited appeal, we also make reasonable attempts to contact the member or their representative to inform them of the decision.

**Notice of resolution or decision**

The written grievance resolution or appeal decision notice includes all required information, including, but not limited to, the following:

- Results of the process and the date it was completed
- Right to request a State Fair Hearing and the processes involved to request a hearing for appeals not resolved wholly in favor of the member
- Right to request assistance in the filing process
- Right to request a continuation of benefits while the State Fair Hearing is pending and how to make such requests
- Notification that the member may be held liable for the cost of those continued services if the hearing decision upholds our adverse benefit determination
- Reference to the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based
- Notification that upon request the member can obtain a copy of the actual benefit provision on which the appeal decision was based and reasonable access to copies of all documents relevant to the grievance or appeal at no cost

## Monitoring grievances and appeals [MS08]

We have established grievance and appeals processes that are further supported with Medicaid best practices acquired through our Medicaid experiences in 16 states. Aetna maintains a comprehensive internal proprietary grievance and appeal application that includes grievances, appeals, and State Fair Hearings. The system allows us to maintain and track all cases from origination through resolution/decision, and to aggregate and trend data on these attributes.

The grievance and appeal application uses the date of receipt to automatically calculate the due date for completion, allowing our staff and managers to track and monitor case timelines. We document all cases in our grievance and appeal application inclusive of those received from the State. Each case is automatically assigned a tracking number/unique identifier that links together all components of the case. This tracking number is used to identify individual cases for processing and to monitor each case throughout the process. All information pertaining to grievances, appeals, and State Fair Hearings are maintained in accordance with the applicable record retention policies and HIPAA standards to protect member privacy.

**The system is all-inclusive – housing all correspondence, letters created, and staff actions taken on the case.** All cases or actions such as Member or Provider phone calls and the overall age of the case are color coded in each staff person's work queue. Past due items display in red, those due in 48 hours display in blue, and those due in greater than 48 hours display in black. This visual display, along with traditional reports, allows staff to prioritize cases and work to ensure timely completion. The application contains a standard suite of reports and queries by case type that the Grievance and Appeal department uses to track cases throughout the process. The grievance and appeal manager uses standard queries and reports within the system to monitor case timeliness and accuracy throughout the process and to identify and report upon trends for potential opportunities for improvement.

We leverage our experience and best practices to ensure that we meet and exceed the requirements in West Virginia. **Current Mountain Health Promise Contract Liaison/Medicaid Administrator – Kathy Szafran - monitors grievances and appeals—including, but not limited to, grievances related to subcontractors—for enabling services for members with physical or developmental disabilities.** Kathy is responsible for monitoring for trends, gaps in care, systemic issues in the program, connecting, and coordinating with local agencies, assisting members and their representatives throughout the process, investigating culture sensitivity issues, and serving as a subject matter expert. Comprehensive staff training provided to assist members and to facilitate smooth operation of the grievance and appeal process to achieve prompt resolution

**Grievance and appeal cross-functional oversight**

We strive to continuously improve program effectiveness through cross-functional oversight, employing our integrated approach to using grievance and appeal system data from complaints, grievances, appeals and State Fair Hearings to effect change. **The committees identified in the following table have representation from across the organization to foster collaborative partnerships and integrate medical functions, operations departments, the provider network, and members into the analysis of grievance and appeal system data.**

| Committee | Grievance and Appeal Role |
|---|---|
| **Service Improvement Committee** | The Grievance and Appeal department reports grievances and appeals to the Service Improvement Committee. |
| **Member Advisory Committee** | The Member Advisory Committee's responsibilities include reviewing and recommending strategies to improve clinical performance measures, cultural competency, member outreach plans, member educational materials (e.g., readability, content) prevention programs, satisfaction survey tools, and other initiatives requested by the Quality Management Oversight Committee. |
| **Quality Management Oversight Committee (QMOC)** | The Service Improvement Committee reports to the Quality Management Oversight Committee. The Quality Management Oversight Committee reviews and evaluates performance monitoring activities, including coordination, customer service, credentialing claims, grievances and appeals, prevention and wellness, provider experience and quality, and utilization management, and population health management. |
| **Delegation Oversight Committee** | The Delegation Oversight Committee advises and makes recommendations to the Quality Management Oversight Committee about delegated relationships. |

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| **Grievance and Appeal Committee** | The Grievance and Appeal Committee reviews and evaluates Member grievances on an ongoing basis; reviews, evaluates, and makes recommendations on identified opportunities for improvement; and maintains records according to applicable regulations and contractual requirements. |
| **Compliance Committee** | The Compliance Committee reviews, monitors, and assesses the effectiveness of our compliance plan. |

## Data, Reporting, and Trending

Aetna's grievance and appeal records are housed in our inclusive system, which houses all correspondence, letters created, and staff actions taken on the case. Member services staff receive updates on grievance and appeal trends via email and during staff meetings, including any policy or program changes supporting those trends. Member services staff use this information to educate members as needed. Our tracking system allows us to capture and report on all information, as outlined in 42 CFR 438. 416. We capture this documentation to meet the DHHR and federal requirements, and because it allows us to maintain and track all cases from origination through resolution/decision.

**The grievance and appeal Contract Liaison/Medicaid Administrator, Kathy Szafran** will continue to utilize standard queries and reports within the application to monitor cases in real time to make certain of timely and accurate resolutions, and manage staff workloads, including reassignment of cases during unscheduled absences such as staff illness. This includes monitoring and reporting on member request turnaround times. Since we began in March 2020, Mountain Health Promise has had only 36 appeals (a strong indicator of member satisfaction). That includes both expedited and non-expedited appeals. **Although we are contracted to turn around an expedited appeal within 72 hours, we turned 100% of the expedited appeals around within 24 hours, and we met the 30-day turnaround time on 100% of the non-expedited appeals.** If we see any evidence of an issue requiring escalation, we act on it immediately.

## 5. Network Development

The Vendor should refer to the relevant specifications located in Appendix 1: Detailed Specifications (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in Section 4: Project Specifications in this RFP, and then describe its approach to Network Development below. The Vendor's narrative response should not exceed 25 pages.

Aetna Medicaid has 35 years of experience managing care for the most medically vulnerable and more than 26 years' experience working with West Virginia health care providers to deliver services to Medicaid members. Through this experience, and as the sole provider of managed care services for Mountain Health Promise since 2020, we have learned that developing and maintaining an all-inclusive integrated care network requires continual assessment of network gaps, ongoing efforts to recruit and maintain providers, and innovative solutions to improve access and quality of services to members. **Currently, Aetna Better Health® of West Virginia (Aetna) meets state network adequacy requirements and has contracts with 14,424 providers,** which comprises more than 3,000 PCPs, over 500 pediatricians, 8,640 specialty physicians, 1,071 behavioral health specialists, and 81 physical health hospitals including adjacent border states. **We are proud of achieving a 100% retention rate among providers over the past two years and an 86% provider satisfaction rate.**

We have established and maintained a solid network of caregivers for children in West Virginia, comprising all 352 West Virginia Federally Qualified Health Centers (FQHCs), inclusive of school-based providers and 72 rural health clinics; 45 local health departments; and 26 critical access hospitals. We keep our focus on foster children's health care issues with touchpoints in their communities such as 26 Right from the Start providers. **Aetna contracts with all available group home providers and those providing services to children with serious emotional disorders (CSED).**

We continually focus on CSED providers as part of our network growth strategy, including telehealth services for CSED/severe mental health, substance use disorder (SUD), and behavioral health. **In the 2021 CAHPS survey, Aetna scored 95% in the "Getting Care Quickly" measure.** We educate providers who do not yet deliver CSED services through one-on-one training, workshops, and webinars, covering the value and benefits of those services.

Throughout our three-year partnership, we have emerged from the pandemic with greater development and usage of telehealth providers. As a result, **there has been a 42% uptick in telehealth usage and greater access for West Virginians in rural areas.** We contract with multiple telehealth services providers and leverage relationships with providers in all five of West Virginia's border states through Aetna Medicaid health plans to provide comprehensive coverage. These include Cincinnati Children's Hospital, University of Kentucky facilities and physicians, Pikeville Medical Center (Kentucky), Big Sandy Health Care (Virginia), Winchester Medical Center (Virginia), and UPMC (Pennsylvania and Maryland).

In support of Mountain Health Promise, our national experience has allowed us to effectively implement new programs and approaches to care and facilitate system changes, particularly for vulnerable populations such as foster care and adoption assistance populations, including those with juvenile justice involvement. Our network, clinical, and quality departments work together in a variety of ways, such as assessing service needs, identifying network enhancements through new providers, and expanding arrangements with current providers, while developing incentives and alternative payment arrangements designed to enhance quality of care and health outcomes for members.

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## [ND01, ND02, ND07, ND08, ND10]

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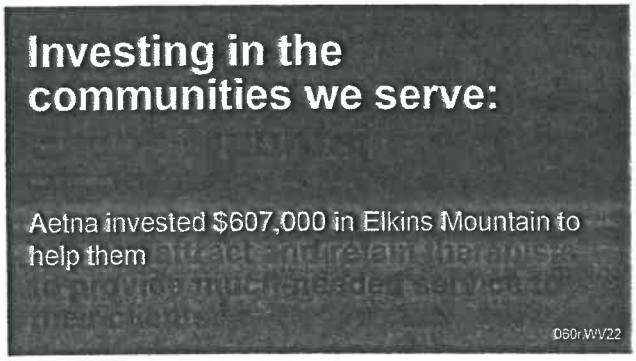
| ND01 | The Vendor should establish a statewide provider network containing providers that can provide a multi-disciplinary and comprehensive service array, either through their own practice or through collaboration with other providers. The network should be accessible to both children and their caregiver(s) and incorporate evidence-based best practices and interventions. |

Having proudly and capably served West Virginia's Medicaid population for more than 26 years, and Mountain Health Promise for the past 3 years, Aetna has an established statewide network that provides a multi-disciplinary and comprehensive array of services to children and their caregivers. **Our network includes every school-based clinic, FQHC, rural health clinic, group home, and CSED provider in the state.** Since 2004, Aetna has had an arrangement with the largest health system in West Virginia, West Virginia University Health System, providing coverage across the state.

We have processes in place to provide evidence of our efforts to contract with all enrolled providers under the State of West Virginia, Department of Health and Human Resources (DHHR) fee-for-service (FFS) Medicaid program. We use the DHHR's PROV12 monthly report to pinpoint FFS enrolled providers who may not be in our network and outreach to contract with them.

When we identify providers not enrolled with the DHHR Medicaid but who are providing services to Medicaid members or would like to join our Medicaid network, such as out-of-state providers or in-state CSED providers, we assist them in enrolling, so they can participate in our network. **Since March of 2020, our efforts to work with providers to enroll as CSED providers has resulted in doubling the number of enrolled CSED providers.**

Our network meets adequacy and incorporates evidence-based practices and interventions through services from the following providers:




- **PCPs:** 3,000+
- **Specialty physicians:** 8,640
- **Behavioral health providers:** 1,071
- **FQHCs:** 352 (includes school-based providers, representing the total number in West Virginia)
- **CSED providers:** 26 (represents the total number in West Virginia)
- **Rural health clinics:** 72 (represents the total number in West Virginia)
- **Acute and behavioral health care hospitals:** 81 (includes in-state and out-of-state)
- **Children's hospitals:** 3 (represents the total number in West Virginia)
- **Psychiatric residential treatment facilities:** 3 (represents the total number in West Virginia)
- **Group home providers:** 34 (represents the total number in West Virginia)

In addition, we are currently under contract with the Bureau for Social Services (BSS) for all the Drug Free Moms and Babies Project sites. This program provides early intervention to mothers and babies affected by SUD.

The breadth of our network ensures we can meet the unique needs and challenges of the diverse Mountain Health Promise population while supporting member choice. We do not limit ourselves to hospital or system-based health care providers and practitioners that demonstrate network adequacy and provider accessibility. We emphasize integrated clinics, FQHCs, rural health care and crisis clinics, post-crisis navigators, and community mental health centers and practitioners. Our providers have deep

knowledge of adverse childhood experiences (ACEs), the juvenile justice system, childhood trauma, and complex, comorbid, or poorly managed conditions.

**Aetna is partnering with a FQHC to establish a community resource center to expand access to care for members in an underserved community by offering in-person care and enabling telehealth.** We are utilizing our strategic partnerships with Community Care of West Virginia to provide select physical and behavioral health services. Because reliable broadband access can be challenging in rural areas, the community resource center will offer a private, comfortable space with a dedicated hotspot and computer equipment to help members easily access telemedicine services and identify available resources. Staff members such as community health workers will be available to assist members onsite. The center will include a wellness room to support programming that connects members to local services and provides access to health and wellness classes, condition management programs, and coaching.

Our goal is to ensure members have choices and access to a wide range of high-quality providers across the continuum of services. **Currently, we meet member access standards for 100% of our PCPs, psychologists, psychiatrists, oncology, and hospitals, and measure above 99% for gynecology, general surgery, cardiology, DME, and home IV therapy.**

## Credentialing and re-credentialing

We credential and re-credential new physical health and behavioral health providers in accordance with federal and state requirements, as defined by the DHHR. **In 2021, we credentialed or re-credentialed 750 individual providers and 232 facilities for Aetna participation.** Individual providers who are members of a contracting group, such as an independent association or medical group, are credentialed individually. We understand the DHHR will provide this information to us to make quality determinations through our Credentialing Performance Committee. **From January through July of 2022, we credentialed 127 new providers with an average turnaround time of 17.77 days, significantly faster than the state requirement of 45 days.** The process for re-credentialing every three years follows the same process and policy as for initial credentialing. In between formal credentialing cycles, we monitor providers as part of our ongoing quality review.

## Collaboration among providers

To improve the member's care and wellness journey, we are enhancing **FamilyConnect, our proprietary, innovative solution that supports seamless coordination of care by making key information available to all authorized individuals in a member's care team, including caregiving providers.** FamilyConnect 2.0 securely stores and provides real-time access to members' assessments; care plans; authorizations; admission, discharge, and transfer data; community resources and social determinants of health (SDoH) referrals; claims; and medications. To support and facilitate continuity of care, FamilyConnect 2.0 will be implemented by quarter 4 of 2022 with progressive enhancements through July 2023. FamilyConnect 2.0 will act as the single source of information to provide alignment in services and goals for physical health, behavioral health, and socially necessary services.

To further enhance care coordination and collaboration, **we will leverage Aetna's health information technology and health information exchange capabilities and experience to continue to collaborate as a full participant of the West Virginia Health Information Network.** We will use our bidirectional data exchange capabilities to interface with and integrate West Virginia Health Information Network data feeds, including admission, discharge, and transfer alerts,

continuity of care documentation, images, lab results, and radiology reports. Aetna will continue to partner with the West Virginia Health Information Network, in their public health data utility role, to connect all member care data and support applicable West Virginia Health Information Network transition efforts. We will support the West Virginia Health Information Network to digitally connect providers, mature and streamline workflow efforts, and support technology innovations, performance improvement possibilities, and health care transformation opportunities. Aetna will offer technology grants to rural providers to cover cost of participation.

## Telehealth to support capacity

Telehealth has become an increasingly significant tool to expand, and supplement, access to care. Teenagers and others in the foster care and adoption assistance programs often find telehealth options to be more convenient or comforting. **Aetna facilitated about 27,700 telehealth visits from July 2021 to June 2022. Prior to the pandemic, only about 1% of services for our members were teleservices. However, at the height of the pandemic, 16% were delivered via telehealth, of which 86% were provided for behavioral health service needs and over 40% were delivered to members in rural locations.**

We currently work with the following telehealth organizations in West Virginia: Bright Heart Health (services for SUD, eating disorders, chronic pain, and co-occurring diagnoses), PursueCare (SUD services) and Groups Recover Together (SUD services with in-person and virtual options).

## Incorporating evidence-based practices and interventions

We assist our network providers in incorporating evidence-based practices and interventions, such as trauma-informed care services through training, incentive programs, and collaboration with other providers. Aetna is committed to advancing evidence-based practices through our Quality Assurance and Performance Improvement program, as required by 42 C.F.R. §438.330(a)(1), and NCQA accreditation standards as well as complying with section 7.2 of the Model Provider Services Agreement. We use evidence-based clinical practice and preventive health guidelines from nationally recognized sources, as our standard of care.

In addition, our value-based contracting arrangements with three large health systems in West Virginia—Charleston Area Medical Center/West Virginia Health Network, University Physicians and Surgeons (Marshall University), and West Virginia University Health System—incentivize and support providers in adopting and adhering to evidence-based guidelines. **More than 20% of Mountain Health Promise members are assigned to a PCP with a value-based arrangement. We will be implementing a value-based program with Marshall Health for the Mountain Health Promise population.** Our value-based program is informed by the Quality Assurance and Performance Improvement program and is focused on quality outcomes (e.g., HEDIS®, CAHPS®, reduction in health and social disparities, and inappropriate utilizations) and state goals.

### Trauma-informed care training for providers

Due to our extensive work and growth in understanding ACEs and trauma-informed care, we have developed effective training protocols and curricula for our providers and staff, in partnership with our Care Advocate Team administrators and the Adverse Childhood Experiences (ACEs) Coalition of West Virginia. This curriculum includes ACEs 101,102, and 103 training modules, which collectively covers 10 types of ACEs, understanding the impact of ACEs on youth and adults, and ways to prevent and overcome ACEs (protective factors and resilience).

### Trauma-informed guidelines to serve children and youth with ACEs

We do not dictate to providers which clinical models they must use in working with youth with ACEs. However, our various training curricula do introduce clinical guidelines and approaches for ACEs/trauma-informed care, and we survey providers regarding which clinical models they use and are trained in. Aetna expects that providers organize their practices and agencies to align with the American Academy of Pediatrics' Trauma Toolbox and Helping Foster and Adoptive Families Cope with Trauma: A Guide for Pediatricians—resources which offer detailed information regarding identifying and responding to trauma.

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| ND08 | The Vendor should develop and implement recruitment strategies for new or modified provider types. The Vendor should describe how it will meet this specification. |

Aetna is committed to continually expanding our network to include new or modified provider types. We understand that the needs of West Virginia's children and families involved in the foster care system and adoption assistance program evolve over time. Similarly, new approaches for delivering whole-person care involve traditional and non-traditional provider types, and we stand ready to provide access to a full range of providers and services. In support of Mountain Health Promise, **we are currently contracted with all CSED providers in West Virginia and have expanded our customized, internally developed provider trainings to support the delivery of CSED services. In 2021, we provided incentives for 12 additional providers to agree to participate as CSED providers.** Our West Virginia recruitment strategies include collaborating with current providers to develop new services and/or supporting providers in recruiting new staff as well as training their existing staff in additional treatment modalities. For example, we have invested in evidence-based training for providers in therapeutics, ACEs, and trauma-informed care.




Aetna collaborates with Crittenton Services for Children and Families, the only residential program in West Virginia for pregnant teens or teen girls who are parenting. Crittenton leads West Virginia in providing trauma-informed care to vulnerable young women who are pregnant. **We provided funding for foster families of girls in residential treatment for a weekend retreat to assist in preparation for the girls and their babies to return home.**

The following examples demonstrate how we have expanded service offerings through recruitment of new providers for telehealth services and helped train existing network providers:

> "The partnership and collaboration we have found with the Mountain Health Promise is always person/family first with an openness for finding creative ways to positively impact the lives of children and families throughout West Virginia."
>
> *— Richard Royse, President and CEO, Crittenton Services, Inc.*

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- **Increasing availability of telehealth:** During the pandemic we increased the availability of specialty telehealth programs for CSED/severe mental health, SUD, behavioral health, maternity/prescribing, and grandfamily/kinship support. As a result, **there has been a 42% increase in telehealth usage and greater access for West Virginians in rural areas.**

- **Supporting providers with parental guidance:** We created parenting modules to help existing network providers train licensed professional counselors to provide parental counseling (with supervision) to expand socially necessary wraparound services.
- **Expanding critical programs:** Aetna supports Pressley Ridge's new Ascend program, featuring a specialized trauma-informed treatment program implementing the neuro-sequential model of therapeutics that is a developmentally sensitive, neurobiology-informed approach to clinical problem solving. Developed by Bruce D. Perry, M.D. Ph.D. this innovative treatment supports youth from going out-of-state for treatment and serves those returning to West Virginia.

> **Partnership with Pressley Ridge**
> "Our partnership with Aetna has allowed us to further expand critical programs/services and resources to those that look to us to be solution-focused, and to create ways to empower youth, families, and communities."
>
> *— Angie Hamilton Thomas*
> *Executive Director*
> *Pressley Ridge*

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- We support the education and training of transitional age youth (ages 16+) on topics such as job preparedness, independent living skills, college preparation, and employment support. Independently licensed behavioral health professionals supervise non-licensed individuals providing the services.

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| ND02 | The Vendor should recruit specialty care providers and hospitals. The Vendor should establish a statewide provider network that has capacity across specialty lines of physical health and behavioral health. For reference, see Appendix 3: Service Provider Agreement (SPA) section 3.1 and Appendix K for an outline of the Provider Network standards.<br>The Vendor should provide a detailed description of how it will meet this specification.<br>Also See Appendix 3, section 3. Provider Network and section 11. BEHAVIORAL HEALTH SERVICES and Appendix K (within Appendix 3) for Provider Network Standards<br>The Vendor should provide a detailed description of how it will meet this specification. |

Aetna's statewide network includes all primary and specialty provider types listed in Appendix 3: Section 3.1 and Appendix K. Our network includes sufficient providers located within the time and distance standards for adults and children. Our provider-to-member ratios for PCPs (1:500 per county for adults and 1:250 per county for children) and OB/GYNs or certified nurse-midwives (1:1,000 per county) similarly meet the required standards. The following describes our capacity across specialty lines of physical and behavioral health:

- **Tertiary hospitals:** All 13 (100%) of the tertiary hospitals listed in Appendix K of Appendix 3, are in our network.
- **Pediatric dental:** Our network exceeds the time and distance standards for pediatric general dentistry (two within 25 miles/30 minutes), oral surgery (one within 45 miles/60 minutes), and orthodontics (one within 45 miles/60 minutes).
- **Behavioral health:** Our network meets the time and distance standards for the provider types listed in Appendix K Section 11 of Appendix 3: adult and pediatric standards (two within 45 miles or 60 minutes travel time). We are contracted with all three behavioral health clinic/psychiatric residential treatment facilities listed for children in West Virginia.
- **Essential community providers:** Our network includes all FQHCs (352, includes school-based providers) and rural health clinics (72) in West Virginia. We make efforts to contract with all essential community providers, including county health departments, Ryan White program providers, and West Virginia Family Planning Program providers.

While meeting all required network adequacy standards, we continually recruit additional specialty care providers, such as CSED providers, group homes, and hospitals with expertise in serving the complex needs of this population. One way we incentivize providers to contract with us is through alternate payment designs, including offering enhanced reimbursement to providers to assure specialty services for members.

Aetna works with organizations providing foster care and other wraparound services, including Safe at Home West Virginia, KVC West Virginia and NECCO. We are fully committed to collaborating with other providers serving these children, youth, and their families, including regional child welfare organizations, and other publicly supported providers.

We also have provided financial support to expand the number of behavioral health providers in West Virginia. **Since the 4th quarter of 2021, we have provided $19.3 million,** including:




- **School-based health centers:** We provided $575,000 to Community Care of West Virginia, an FQHC with multiple locations, to increase staffing for behavioral health services within school-based health centers.
- **Tertiary centers and inpatient psychiatric facilities:** During the pandemic, we provided $3.37 million to assist providers such as River Park Hospital and Highland-Clarksburg Hospital to address severe staffing shortages. Charleston Area Medical Center and St. Mary's Medical Center received educational and learning funding totaling $2.025 million.

We complete quarterly assessments of our network and annual GeoAccess® reviews of provider types to determine network needs and to develop contracting solutions. Aetna considers several factors when recruiting network providers for this specialty population, including member need within the following:

- Clinical expertise
- Open panel
- High-volume referrals
- Specialties
- Geographic location (considering distance, travel time, means of transportation, and access for members with physical disabilities)
- Telehealth and specialty telehealth programs
- Expertise with Mountain Health Promise program and members

Aetna's provider network is approved, meets time and distance standards as referenced in Attachment G-5.

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| ND07 | The Vendor should develop and implement a recruitment strategy for the following publicly supported providers:<br>• Local Health Agencies<br>• Critical Access Hospitals<br>• Primary Care Centers<br>• School-Based Health Centers (SBHCs)<br>• Right from the Start (RFTS) Providers<br>• Bureau for Public Health (BPH) Laboratories<br>• Children with Special Health Care Needs (CSHCN) Program<br>• Federally Qualified Health Centers (FQHCs)<br>• Rural Health Clinics (RHCs)<br>• Indian Health Providers<br><br>If the Vendor elects not to contract with these publicly supported providers, the Vendor should develop and implement a strategy to ensure all members have access to services.<br>The Vendor should describe how it will meet this specification. |

Throughout our partnership with the DHHR, we have consistently developed and maintained a network of publicly supported providers, including all FQHCs, rural health clinics, and school-based health centers in West Virginia. We are currently contracted with:

- **Local health agencies**: 45 (100% of the local health agencies that provide Medicaid-reimbursable services)
- **Critical access hospitals:** 26
- **Primary care centers:** 31 (all community health centers)
- **School-based health centers:** 100% of providers
- **Right from the Start providers:** 26
- **West Virginia Bureau for Public Health:** public health laboratories can bill Aetna regardless of network status
- **Children with Special Health Care Needs program:** 100% of providers
- **FQHCs:** 100% of providers
- **Rural health clinics:** 100% of providers
- **Indian Health Providers:** compliant with 42 CFR 438.14 related to Indian Health Providers

Aetna will fully comply with all contracting, payment, and service delivery requirements related to publicly supported providers, as detailed in the Service Provider Agreement Section 3.

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| ND10 | The Vendor should develop and implement recruitment strategies to increase capacity of PRTFs statewide to address severe mental health challenges such as sexual abuse, fire starting, combativeness, and severe conduct disorder behaviors.<br>The Vendor should describe the process and procedure for how it will meet this specification.<br>Also See Appendix 3, section 13 13. CHILDREN'S RESIDENTIAL TREATMENT FACILITIES/EMERGENCY SHELTERS p195 |

We have successfully employed several strategies to expand the psychiatric residential treatment facilities capacity to address severe mental health challenges such as sexual abuse, fire starting, combativeness, and severe conduct disorder behaviors. **Foremost, we want to relieve the pressure on psychiatric residential treatment facilities by ensuring children are in the appropriate, least restrictive level of care at the right time.** Our strategies include:

- Partnering with several in-state providers to offer a higher level of care (Level 3 to psychiatric residential treatment facilities)

- Working with Highland Hospital and the West Virginia Hospital Association to invest in the hospital reopening of the pediatric unit to add psychiatric residential treatment facilities beds
- Working with River Park Hospital to reopen their children's acute unit
- Connecting our care coordinators with providers on discharge planning for members in psychiatric residential treatment facilities, ensuring members are in the right level of care at the right time
- Implementing innovations to promote kids in a community environment, such as the inclusion of embedded staff at key providers/facilities and the BSS offices, and the expansion of our CSED team
- Providing incentives to in-state providers to develop specialized care
- Working with KVC West Virginia, Pressley Ridge, the State, providers, and other stakeholders on strategies to increase reimbursements to foster parents and foster group homes
- Offering a supplemental foster care rate for high-intensity members, which supports the State's goal to reduce institutionalization and keep kids in the home
- Assessing all in-state residential care using the Child and Adolescent Functional Assessment Scale every three months. If their score is less than 90, they would move out of residential care. Our care coordinators will engage providers and the BSS worker to develop a discharge plan, treatment plan, barriers to discharge, and creative solutions to move the child to a lower level of care. We will assist and coach the State to employ Family Finding tools to identify families and caring adults with existing relationships or ties to the child for potential placement.
- Working with provider partners such as Children's Home Society of West Virginia to support additional staffing in level 4 emergency shelters. We want to remove any barriers and increase capacity for all shelter care, residential and psychiatric residential treatment facilities, to pre-pandemic levels.

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| ND03 | The Vendor should measure and regularly verify network compliance standards. The Vendor should ensure member access to covered services in areas where the provider network standards do not require a specialist. The Vendor should also address deficiencies in the Essential Provider and Specialty Provider networks in relation to travel times and distances that may be experienced by a member.<br>The Vendor should describe how it will verify network standards to ensure member access. The Vendor should describe what constitutes a deficiency in the Essential Provider and Specialty Provider networks, based on its understanding of Agency provider network standards, and its approach to addressing these deficiencies.<br>See Appendix 3, sections 2.1 Covered MCO Services, 2.4 Non-covered Services, and 3PROVIDER NETWORK |

We use a variety of tools and reports to measure and verify that our network meets or exceeds the DHHR compliance standards. Our network is robust and complies with 42 CFR §438.206(b)(1), providing access to hospitals, PCPs, dental, specialty care providers, residential treatment providers, and the Bureau for Children and Families' approved non-traditional providers. These providers carry out socially necessary services in sufficient numbers and in geographically accessible locations to make available all covered services as required by the availability and access standards of the Model Purchase of Service Provider Agreement. In accordance with 42 CFR §438.207, our network provides sufficient number, mix, and geographic distribution of providers.

Our network includes primary care and specialist providers trained or experienced in trauma-informed care, treating individuals with complex needs, and identifying child abuse and neglect.

We understand the elements that constitute a deficiency in the essential provider and specialty provider networks, according to contractual time and distance adequacy standards, and that the MCO will be

prohibited from serving members in the deficient geographic areas. **Aetna has never been deficient in a geographic area while managing Mountain Health Promise.**

## Monitoring to verify network compliance

We measure our network using provider-level reports, HEDIS reports, grievances and appeals, survey data, claims data, community needs assessments, heat maps, time, and distance studies, and provider-to-member ratios. We drill down into provider data by services provided, provider type and relevant provider characteristics. The table below provides a detailed list of these reports.

| Reporting and monitoring activity | Schedule | Data or report description |
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| **Emergency Department utilization dashboards** | Quarterly | Continuous monitoring is performed using operational dashboards that measure and trend member utilization including emergency department care. These dashboards allow us to identify opportunities to enhance our network by location, disease state, and member type. |
| **Interdepartmental reporting** | Monthly | We have implemented a formal interdepartmental process that allows the Provider Relations department to collect, trend, and respond to network needs our staff may identify outside of the other data and reporting mechanisms, such as challenges identified by our care coordinators or informal discussions with community organizations, including access or capacity concerns related to special needs |
| **Call center encounters data** | Monthly | Our call center collects information regarding member calls about network provider availability and access, and shares the call information with the Provider Relations team to assess potential network gaps, barriers, and opportunities for network development |
| **Member and provider appeal and grievance data** | Monthly | We review analysis and trending of appeal and grievance cases to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, when necessary |
| **GeoAccess reports** | Annual | We review GeoAccess reports to measure compliance with the DHHR access standard requirements for each ZIP code |
| **PCP-to-member ratios** | Annual | We review ratios by provider type and region to confirm availability of an adequate number of PCPs |
| **Network adequacy** | Annual | We review utilization data including prevalent conditions, single-case agreements, provider referral issues (availability of specialties), providers gained and lost, and unplanned network exits to confirm sufficiency of the type and number of providers |
| **Network panel studies** | Annual | Network panel studies are performed, using the open/closed panel report, to assist in assessing network access and availability needs and identify providers who have reached their capacity |
| **Provider directory audits** | Annual | These audits confirm the accuracy of provider listings and are used to make weekly updates to online directories, including changes in demographics and panel status |
| **Provider appointment availability surveys** | Annual | To improve monitoring of access for the population served under this contract, we query providers on appointment availability, open scheduling, and after-hours care |
| **CAHPS survey** | Annual | We review and analyze CAHPS survey results and create action plans for improvements identified through the survey |

In addition to quantitative metrics, we use qualitative methods such as feedback we receive from members, regional provider forums, community organizations, agency partners, and our own staff.

## Capacity and assignment of PCPs

As required by the Services Provider Agreement Section 3, Aetna monitors PCP panels for compliance with the Bureau for Medical Services' limit of Medicaid members assigned per PCP, for applicable populations.

Our established policies and procedures for monitoring participating PCP panel status and capacity include:

- PCP capacity, including metrics to maintain compliance with the limit of 2,000 members per each PCP
- PCP notifications of panel size
- Changes in the PCP panel status

In addition, a component of our provider training includes identifying specialists who want to serve as a PCP.

We use the following tools and approach to verify network standards and ensure member access:

- **Monthly reports:** We provide monthly reports of current assigned members, no later than five business days after the end of each month unless the PCP has agreed to an alternate schedule. PCPs can also access this report through our secure provider portal.
- **Claims and utilization data:** We monitor claims and service utilization data and inform our network development and provider recruitment teams to identify potential needs. If we identify gaps, or potential gaps, we work to expand the network and ensure ongoing timely member access to PCP services.
- **Out-of-network recruitment:** We use data on single-case agreements and our annual out-of-network report to identify providers for recruitment into our network.
- **PCP team:** We have processes that address PCP ratios in circumstances involving PCP teams, such as teaching facilities where residents and physicians' assistants serve as a PCP, under the supervision of an attending physician.
- **Excess caseloads:** If we identify or receive notification that the DHHR has identified a PCP total Medicaid member caseload that exceeds the 2,000 Medicaid member limit, we analyze the assigned membership and either reduce the caseload for the PCP or seek an exception. Aetna works with the PCP and the DHHR to obtain consent for any exceptions and will request for exceptions as required by the Department, including the following: continuation of established care; assignment of a family unit; availability of mid-level clinicians in the practice that effectively expand the capacity of the physician; and inadequate numbers of providers in the geographic area.

## Provider cultural competency

In accordance with 42 CFR §438.206(c), we ensure services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. We also ensure our network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.

We conduct onsite visits to ensure providers are meeting these requirements.

## Addressing network deficiencies

**We understand that network adequacy and access to care are not the same.** Even though the size of our West Virginia network is robust, we continually monitor our network to ensure members have access to the services and support they need and to prevent deficiencies. **We collaborate with associations, community organizations, hospitals, and academic organizations for new providers entering the area, or to develop relationships to meet specific needs if there are deficiencies, such as providing telehealth or community solutions to maintain and increase network accessibility, especially in the identified geographic areas and scarce provider specialties.** Furthermore, we encourage providers to participate in alternative payment model (APM) arrangements that incentivize cost utilization and quality achievements as a way of addressing adequacy issues.

We currently have Care Connection teams co-located with providers in all five regions across West Virginia. The community presence of these teams helps identify and resolve potential gaps in network accessibility. These teams have established relationships with the DHHR, BSS, Office of Juvenile Justice Prevention, Bureau for Medical Services, and Bureau for Behavioral Health. They also have deep relationships with provider and community service agencies to support smooth implementation of individual care plans.

Our proactive strategies to prevent and swiftly address potential network gaps or access to care challenges include:

- **Members:** We listen to the feedback we receive directly from members through our Member Advisory Committees, evaluating member complaints, through member satisfaction surveys, and member referrals.
- **Providers:** We provide multiple forums to solicit provider feedback, including during our provider trainings, through feedback from our Providers Relations teams, by monitoring provider complaints, through provider satisfaction surveys, provider referrals, and by participating in provider association meetings including the West Virginia Primary Care Association. In addition, we hear providers' voices through their participation on the Quality Management/Utilization Management Committee.
- **Governance roundtable:** These are stakeholder collaborations and meetings made up of health care professionals, advocates, and members to discuss issues, including network adequacy and recruitment priorities for growing the network

## Ensuring access to covered services where the provider network standards do not require a specialist

Through our vast experience working with high-needs children and youth, including those involved in the foster care system and adoption assistance programs, we know the importance of providing access to a wide array of specialist services in a way that maintains the child's connection to local community supports. Our goal is to provide access to all socially necessary services for the children and youth enrolled in this program, and to improve health and quality of life outcomes.

We recognize that certain regions and counties in West Virginia present greater challenges in offering easily accessible services due to limited or no availability of certain specialty providers in those areas. To make sure members in these regions have access to covered services, we have developed a variety of solutions and initiatives that may be used depending on the specific member circumstances and needs. **These include continued growth of CSED providers in our network and accessibility to a**

**community resource center with alignment to an FQHC, providing localized care and access to telehealth services.**

To increase access to pediatric specialty services such as endocrinology, we routinely leverage the established provider relationships of Aetna's affiliated health plans to establish agreements with border state providers in all five of West Virginia's border states. In many cases, access to those providers improves access to specialty providers and reduces member travel time because border state providers are located closer to West Virginia members than in-state providers.

We want to keep West Virginia Medicaid dollars in state whenever possible and only pursue out-of-state options when access does not exist. We collaborate with Aetna's affiliated health plans to assess and identify opportunities to improve service delivery for children and youth in the foster care and adoption assistance program. Aetna currently has letters of agreement or contracts with Cincinnati Children's Hospital (Ohio), University of Kentucky facilities and physicians, Winchester Medical Center (Virginia), Pikeville Medical Center (Kentucky), Big Sandy Health Care (Virginia), and UPMC (Pennsylvania and Maryland).

We also pursue single-case agreements if a non-contracted specialist is available near the member's location, as well as facilitate access through telemedicine and telehealth, as permitted by state laws and regulations.

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| ND04 | The Vendor should provide monthly reports to the Agency, by a date established by the State, on underserved areas of the State where the Vendor believes additional socially necessary services (SNS) providers should be permitted to enroll to address a gap in care.<br>The Vendor should describe how it will meet this specification.<br>Also See Appendix 3, section 12, SOCIALLY NECESSARY SERVICES (SNS)p193 |

Aetna provides a monthly report to the BSS on underserved areas in collaboration with our subcontractor for socially necessary services, Kepro. Kepro analyzes the services authorized in each county and compares that data to Child Protective Services and Youth Services case count data for each county. Aetna and Kepro identify the counties where additional socially necessary services providers would be beneficial and make recommendations to address a gap in care. In addition, we monitor for service gaps/ provider closures via the underserved areas report and monthly contract management meetings with Kepro. We then share that information with the BSS.

## Understanding members' needs

Over the past two and a half years, **we have conducted 48 focus groups with youth, families, and foster parents that reside in the community.** These focus groups serve as an opportunity to provide the DHHR with feedback on where services are creating the most impact to facilitate making programmatic changes to improve the overall health of the program. We collaborated with the Bureau for Children and Families on the questions used in the focus groups, including sessions on gaps in care. We reported these insights to the BSS Community Partnerships for inclusion in West Virginia's Annual Progress and Services Report (APSR) to the U.S. Office of the Administration for Children and Families (part of the U.S. Department of Health and Human Services).

As we have collectively summarized our findings from the focus groups, **we have identified five areas for growth** based on improvements and consistent themes.

- **Trauma-informed care:** Increasing training for all child welfare stakeholders to reduce the use of out-of-home care
- **Trust:** Engaging in practices that allow individuals to seek assistance without fear of repercussion

- **Collaborations:** Continuing focus on collaboration between the various areas of the child welfare system
- **Services:** Building quality services to support children and families within their communities
- **Information sharing:** Providing additional information to caregivers about child welfare and the resources available to help

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| ND05 | The Vendor, and/or any benefits management subcontractor(s), should monitor and evaluate ongoing access to services, including, but not limited to, time/distance, appointment timeliness, and by provider type. The Vendor should take action if notified of inappropriate wait times before a member is seen by a provider.<br>The Vendor should provide a detailed description of the methods it will use to meet this specification. The Vendor should also describe its standards for member wait times.<br>Also See Appendix 3, section 6.5, Rural Option p144 |

Aetna's statewide, comprehensive network complies with state availability and access standards.

We continuously monitor our network to identify network gaps and opportunities to improve in providing our members with choice and timely access to high-quality providers. Aetna has amended its network accessibility standards for Mountain Health Promise, consistent with the DHHR requirements, and implements changes to such network standards, including county and region-specific requirements applicable to the DHHR-identified, frequently used specialists.

**Strong CAHPS result for access to care**
In the most recent CAHPS survey, Aetna Better Health scored 93% in the "Getting Needed Care" measure.

We will continue to meet the standards for timely access to care, including:

- **Regular/routine PCP (non-urgent):** Within 21 calendar days. Two providers within 20 miles or 30 minutes travel time.
- **Specialist (new patient initial):** Within 90 days. Frequently used specialist: Two providers within 20 miles or 30 minutes travel time. Other specialist: One provider within 20 miles or 30 minutes travel time.
- **Specialist (existing follow-up):** Within 30 days. Frequently used specialist: Two providers within 20 miles or 30 minutes travel time. Other specialist: One provider within 20 miles or 30 minutes travel time.
- **Behavioral health (initial/routine):** Within 10 business days. Two providers within 45 miles or 60 minutes travel time.
- **Behavioral health (routine/follow-up):** Within 60 days. Two providers within 45 miles or 60 minutes travel time.
- **EPSDT service:** In accordance with EPSDT guidelines and periodicity schedule within 30 days
- **Urgent care:** Within 48 hours
- **Emergency care:** Immediately or referred to emergency department facility
- **Non-life-threatening behavioral health emergency**: Within six hours
- **Discharge follow-up visit:** Within seven days

We provide after-hours access to a network PCP 24 hours a day, 7 days a week. After-hours calls for urgent problems are returned immediately. Non-urgent calls are returned within 30 minutes.

As the single MCO in a rural county, Aetna allows members to choose from at least two PCPs, and to obtain services from an out-of-network provider under circumstances according to 42 CFR §438.52. We use tools such as single-case agreements to work with out-of-network providers and make efforts to contract with those providers for our network.

## Identifying service needs and gaps

As a component of our current network analysis and recruitment strategies, we regularly review reports of Medicaid-enrolled providers and outreach to any non-contracted providers. Through this process, Aetna continues to maintain a network that mirrors the Medicaid-eligible providers, to the extent possible. As a result, we are well-positioned to proactively address network availability and accessibility changes. In addition to ongoing efforts to contract with eligible Medicaid providers, **we leverage our deep knowledge and experience working with local communities and providers across West Virginia, to proactively identify services needs and gaps, and develop creative solutions for making sure members in Mountain Health Promise have access to all necessary covered services in a timely manner.** Specific strategies we use include collaboration with Kepro, SNS providers, and out-of-network providers. We also leverage border-state providers, such as Cincinnati Children's Hospital, University of Kentucky facilities and physicians, Pikeville Medical Center (Kentucky), Big Sandy Health Care (Virginia), Winchester Medical Center (Virginia), and UPMC (Pennsylvania and Maryland).

Our network development director is responsible for identifying network gaps and opportunities for improving and monitoring the network of providers to make sure identified needs are promptly acted upon. Our Care Advocate Team meets routinely with the network development director and provider relations director to review network adequacy data, identify opportunities for network enhancement and growth, and review the status of the recruitment plan.

## Monitoring provider compliance

We monitor provider compliance with required time, distance, and appointment wait time standards under Mountain Health Promise. We contractually obligate all participating providers in our network via provider agreements to adhere to timely access and appointment standards, including specific standards for specialty, urgent, and crisis services.

Our monitoring of provider compliance with these requirements includes monitoring accessibility reports, member concerns, and making onsite visits. Aetna surveys network providers telephonically to ensure they are compliant with state contract requirements for getting a member in for care. **Aetna has had no provider fail the survey twice.** If a provider fails the survey, a provider relations representative outreaches to the practice to educate on the access standards. If the provider fails a second time, we request a corrective action plan detailing how they will meet the accessibility requirements. Aetna will monitor the plan for completion. We communicate standards for wait times and appointments, disability access, competency, expertise, cultural sensitivity, and hours of operation through the provider manual, provider forums, during site visits, and in training documents. In addition to our standard monitoring activities, we monitor compliance with Mountain Health Promise requirements through our integrated system of care model to support members and providers.

## Provider incentives

Provider, plan, and state incentive payment alignment is an important strategy for keeping the member's support ecosystem in sync for the delivery of the right care in the right place at the right time. Our value-based contracting arrangements with three large health systems in West Virginia—

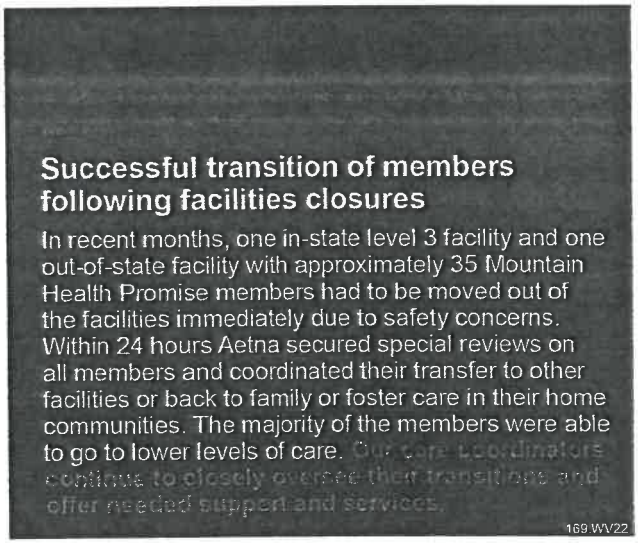
Charleston Area Medical Center/West Virginia Health Network, University Physicians and Surgeons (Marshall University), and West Virginia University Health System—incentivize and support providers in adopting and adhering to evidence-based guidelines. **More than 20% of Mountain Health Promise members are assigned to a PCP with a value-based arrangement. We will be implementing a value-based program with Marshall Health for the Mountain Health Promise population.**

Our value-based payment program is based on Aetna's Quality Assurance and Performance Improvement program and focuses on quality outcomes (e.g., HEDIS, CAHPS, reduction in health and social disparities, and inappropriate utilizations). We also provide extensive technical assistance, particularly to practices with value-based payment contracts, through our practice transformation specialists, who coach providers on use of data and reports (e.g., gaps in care, emergency department utilization), member value-added services, provider incentives, integrated care practices, and the use of behavioral health screening tools. In addition, we support PCPs with a combination of timely information sharing, care coordination, provider education, and provider incentives for superior performance based on the timely completion of comprehensive medical, dental, behavioral, and SDoH evaluations, and age-appropriate immunizations.

Our overall value-based payment programs differentiate us from our competitors through foundational payments for infrastructure and operations and the percentage of provider payments, PCPs, and members in value-based payment programs. We also pre-pay providers to ensure availability of services with limited capacity such as bed space at skilled nursing facilities and behavioral health hospitals. We prioritize building provider relations through one-on-one education, web-based, on-demand trainings including offering continuing education credits, provider support in resolving problems, and supporting timely provider communications via our provider portal, network notifications, and one-on-one interactions with our provider support teams.

## Supporting members and providers in scheduling appointments

We use our integrated system of care model to support members and providers with improving the outcome of their health. Children and youth served under this program have an assigned Aetna care coordinator. The assigned care coordinator is responsible for supporting members, their parents (including foster and adoptive parents), fictive kin, legal guardians, and providers with access to necessary services, including transitions in care and scheduling appointments when needed. When specific challenges are identified, the care coordinators work with the Member Services and Provider Relations teams to address unique needs or access to services. Care coordinators outreach to the Provider Relations team for assistance in finding providers who are available to provide specialized services. Member Services staff are also available to directly assist members in obtaining the appointments to further support member access to timely services.




Because of our intensive monitoring and outreach activities with providers to ensure compliance, **we actively support our PCPs in the scheduling of appointments for cardiologists, dermatologists, endocrinologists, licensed mental health specialists, neurologists, OB/GYNs, orthopedists,**

**psychiatrists, and pulmonologists.** We also recognize that providers benefit from additional support, which includes call center support to identify and contact specialists accepting new members and help schedule appointments, and locally embedded provider relations support, care management outreach, and field-based community health workers. Our Provider Relations team meets regularly with Care Management and Member Services staff to respond to individual needs and to identify trends for targeted network development.

## Resources and methods to support adherence to adequacy standards

We conduct network adequacy data analysis activities, reviewing data from various reports and sources (described in this response) at state, regional, and county levels to assess for adherence to minimum time/distance, minimum provider number, and appointment access and availability standards. They also evaluate impacts of provider terminations, which are rare considering **Aetna has a 100% retention rate the past two years.** Network and Provider Services staff review this data and information in workgroups with representatives from Aetna's Quality Management, Utilization Management, Grievance and Appeals, Informatics, and Member Services departments in regularly scheduled workgroups. The workgroups discuss factors that may be contributing to network adequacy or appointment standard noncompliance and discuss solutions and contracting strategies to address these challenges. Solutions for network adequacy or appointment standard noncompliance will be implemented if they are necessary.

## Data analytics

Our Network staff uses Quest Analytics geographic analyses to comprehensively evaluate the network against time/distance and minimum provider number requirements. During initial network building and through implementation, we conduct analysis weekly. Once the network has met adequacy standards, we perform monthly analysis, and after a period of sustained adequacy, the analysis is changed to quarterly. Staff also review other data elements to assess for compliance with network adequacy standards including:

- Ongoing active evaluation of network additions and terminations occurs to identify trends or provider terminations that could lead to a network gap
- Results of our annual provider satisfaction surveys incorporate feedback from network participants on satisfaction of available providers
- Evaluation of CAHPS survey results assesses member satisfaction with access to care
- Information from Care Management staff (based on care coordination activities) that identifies possible network inadequacy or inaccessibility is included in analysis
- Feedback from other internal departments, such as Quality Management, Member Services, or Grievance and Appeals or system partners identifies anecdotal or systemic issues
- Evaluation of provider test cases, which capture provider compliance with the DHHR appointment access and availability through telephonic provider surveys

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## [ND06]

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| ND06 | The Vendor should offer crisis response to children and their caregiver(s), as well as families at risk, to the extent that these services are covered under the Bureau for Medical Services (BMS) Children with Serious Emotional Disturbance Waiver (CSEDW).<br><br>Information on the WV CSEDW can be found at the following link:<br>dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx<br>The Vendor should describe how it will meet this specification.<br>Note: Although not all populations in the specification are included in the scope for this procurement, the Vendor should demonstrate an understanding of the populations listed. For crisis services outside the Children with Serious Emotional Disturbance Waiver (CSEDW), the Agency may carve in these services at a later date. |

Aetna understands the goal of supporting CSED by helping to keep members with their families and in their homes by providing an integrated network of care. We offer crisis response to children and their caregiver(s), as well as families at risk, to the extent that these services are covered under the Bureau for Medical Services CSED waiver.

Crisis response is essential for children accessing CSED waiver services based on the risk presented by the most common diagnoses (based on waiver claims in the second half of 2021): attention-deficit/hyperactivity disorder, conduct disorder, cyclothymia, schizoaffective disorders, post-traumatic stress disorder, and autism spectrum disorder.

Upon approval for the CSED program, an Aetna CSED waiver case manager contacts the legal guardian to discuss the CSED program and services available. The case manager will give the legal guardian the 1-844 Help-4WV phone number to access mobile crisis response services through the Bureau for Behavioral Health until CSED waiver providers are chosen within 10 days. The case manager assists the member and legal guardian with completing and administering the provider selection form.

**Mobile response services keep teen safe, in home**

Megan, 17, has frequent dysregulated periods due to schizoaffective disorder, including episodes of self-harm (cutting) and hitting her mother. Megan was immediately remorseful after these incidents. She had had a traumatic experience at a psychiatric residential treatment facility in the past and was deeply concerned her actions would cause her to be sent away again.

Megan's mother began using mobile response services from a local CSED agency. Megan quickly learned she could initiate these calls herself without having to wait for her mother to recognize she was in crisis. Instead of cutting herself or breaking things, Megan would call her CSED provider's mobile response. Megan began to understand she was the driver in her choices, and that she had options to help her cope. Prior to the availability of mobile crisis response, she averaged two incident reports per week for cutting or assaultive behavior. Currently, she has not had an incident report in months. Megan and her family credit mobile response for keeping them safe and keeping Megan in her home and community rather than an institution.

In some counties, responsibility for providing mobile crisis response services will shift to the CSED providers that the member and their caregivers select. They provide a 24/7 phone number, and all calls are returned within one hour. The provider and child and family team develop a prevention plan within 72 hours. As part of the child and family team, the provider continues to conduct crisis follow-up services for up to seven weeks following the event.

In counties where there are no CSED providers that provide crisis response services, the member or their caregiver will continue to access crisis response services through the Bureau for Behavioral Health.

Family members needing support for themselves can call 844-HELP-4WV, which offers a 24/7 call, chat, and text line that provides immediate help for any West Virginian struggling with an addiction or mental health issue.

## [ND09]

| | |
|---|---|
| ND09 | The Vendor should establish and implement guidelines for which specialists will be able to serve as a primary care provider (PCP) for populations eligible for medical services, including, but not limited to:<br>• The circumstances and process under which a member may select a specialist as his/her primary care provider (PCP)<br>• Any managed care organization (MCO) approvals required<br>• Any restrictions on the types of specialists that can serve as primary care providers (PCPs) for foster care members or other members with complex needs<br>1. The Vendor should provide proposed guidelines.<br>2. The Vendor should describe its proposed processes to meet these specifications. |

We have established guidelines, communicated through new member outreach, and published in the welcome packet, to determine which specialists will be able to serve as a PCP for populations eligible for medical services. **We have the flexibility to add different types of specialists to serve as PCPs to best support members.** We have designated the following providers as appropriate to serve as PCPs:

- Advanced practice nurses (nurse practitioners and clinical nurse specialists)
- Physician assistants
- Physicians with the following specialties: general practice, family practice, internal medicine, OB/GYN, and pediatrics

A member may request another type of specialist not listed here to serve as PCP using the process described below. There are a variety of circumstances in which a member might select a specialist as their PCP. For example:

- A pregnant member might not have established care with a PCP, so their OB/GYN becomes primary for the duration of the pregnancy
- An HIV/AIDs specialist might become primary because of the complexity of the treatment
- A provider specializing in gender-related medicine might become primary if a member is undergoing gender transformation

### Process for requesting a specialist to serve as PCP

We have an established process for members seeking to designate a provider type not listed above as their PCP.

- **Member education:** As part of our welcome packet and new member outreach, we notify members with disabling conditions, chronic illnesses, or who are Supplemental Security Income-eligible, that they may choose a specialist physician to serve as their PCP, provided the specialist physician agrees to perform all PCP duties required in the contract and that such duties are within the scope of the specialist's license.
- **Member or provider-initiated request:** Any member, parent or legal guardian, or a provider may request that a specialist perform as the member's PCP. They can do this by contacting the Member Services or Provider Services department. We advise the member that we will contact the provider and request that the provider submit confirmation of their agreement to serve as a PCP, and for assuming responsibility for all PCP-specific requirements. Our Member Services staff also recommend that the member directly contact the specialty provider to aid in expediting the request.

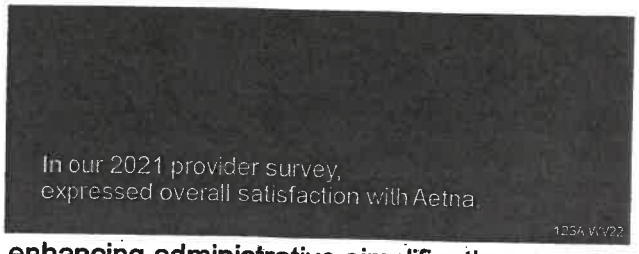
- **Provider outreach:** We will send the identified specialist a notice informing the specialist of the member's request and information regarding requirements if they choose to serve as a PCP, including:
  - Conducting coordination of care
  - Providing EPSDT related services, as appropriate
  - Completing PCP provider trainings, as appropriate
  - Affirming the provider's capacity to render timely PCP services
- **Medical director review:** Upon receipt of written confirmation that the specialist agrees to serve as the PCP, including all required PCP activities, the medical director, or their physician designee reviews the request. Reviews are conducted on a case-by-case basis and include verifying that required PCP services are within the scope of the specialist's provider license.
- **Approval:** When a specialist provider serves as a PCP, we monitor the specialist's provision of PCP services, as required, through the mechanisms generally used to monitor PCP services, including review of data through the West Virginia Health Information Network, claims data, and record reviews.
- **Denial:** If a request for a specialist to serve as a PCP is denied by Aetna, the member is notified of the decision, the reason for the denial, applicable grievance, and appeals rights, and how to file a grievance or appeal with our Member Services department.

## 6. Provider Services

**The Vendor should refer to the relevant specifications located in Appendix 1: Detailed Specifications (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in Section 4: Project Specifications in this RFP, and then describe its approach to Provider Services below. The Vendor's narrative response should not exceed 25 pages.**

Aetna Better Health of West Virginia (Aetna) views providers as partners in our shared effort to provide high-quality care to the members of the State of West Virginia, Department of Health and Human Resources (DHHR). As a partner in improving health outcomes, we support providers through the people we hire, the technology we use, the innovations we implement, and the training we provide.

Aetna is committed to providing excellent member support for foster children and their caregivers, we strive to maintain and strengthen the long-lasting relationships we have built with our provider partners. We do this by listening, evaluating, and continually improving our processes to support providers. This includes but is not limited to providing timely payments, enhancing administrative simplification, communication, and furthering the quality goals of DHHR.




Our provider service model is localized to the specific geography and population each provider serves and includes staffing for contracting, credentialing, and provider services. **Our strategy is designed to give providers the ability to do what they do best – take care of members.** The tenets of our provider service model build on each other and are simple yet effective:

- **Streamline the basics** – Maximize the time providers spend with Medicaid members by simplifying administrative actions
- **Provide the right support** – Provide multi-faceted support through a locally based Provider Support Provider Optimization Delivery (POD) that partners with providers in a flexible model and varying in intensity based on need, data insights that increase quality, and provider payment strategies for improving population health
- **Innovate to differentiate** – Identify creative opportunities to improve population health by addressing barriers to care and delivering health solutions beyond the office setting

### Streamline the basics

**The most effective use of providers' time is with their patients. Inefficiencies associated with extraneous administrative actions can impact the quality of care.** This ideology is affirmed through our discussions with West Virginia providers and provider associations where common themes include the need to reduce administrative burden and simplify prior authorization processes. **We have reduced prior authorization for nearly 800 procedure codes.** To streamline the basics, we:

- **Achieve contracting efficiency** by simplifying provider agreements, credentialing requirements, and provider onboarding
- **Align local, contracting resources** that provide an immediate alternate escalation to address provider concerns
- **Conduct annual review** of and optimize prior authorization requirements and identification of gold card opportunities for high quality providers

- **Provide technical assistance** on national coding standards, HEDIS®, and best practices on claims submission; and train provider office staff on the user-friendly provider portal to maximize self-service

## Provide the right support

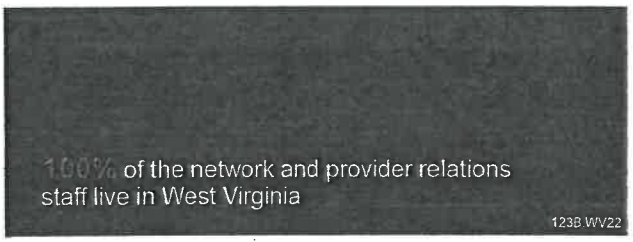
We're excited to announce the roll out of a new provider support model across West Virginia, beginning January 2023. Our new Provider Support POD is designed to ease provider burden through hyper-local, multi-faceted support. Our experience in West Virginia shows that provider support should be flexible and vary in intensity to meet the needs of each individual provider. To this end, our Provider Support PODs seek to partner with providers to ease administrative burden, share data insights that increase quality, and adopt innovative payment strategies that improve population health.

**Given our long history with Medicaid providers in West Virginia, most of our providers have strong relationships with Aetna and know who to contact and where to go for support at any time.** In addition to long-term provider partners, new providers are continually joining our network, expanding our reach and the scope of services we offer. **We support all our contracted providers at a level that best meets their needs.**

We continue to support providers through local staff and meaningful technology. **Our multidisciplinary Provider Support PODs include uniquely trained provider support professionals with differing backgrounds and expertise, to give network providers a comprehensive support structure for all their Medicaid needs**. Each POD is made up of professionals who live and work in the communities they serve. The responsibilities of Provider Support POD professionals include:

- **Provider Services Representative**: Serves as the main point of contact for providers, developing relationships to better understand and address each provider's unique challenges.
- **Quality Practice Advisor**: Delivers and reviews gap in care reports for preventive care or disease management services per clinical and contractual guidelines. Other duties include tracking provider performance for HEDIS compliance, providing NCQA and HEDIS technical specification updates, and developing and delivering current scorecards and measure-focused improvement action plans.
- **Provider Operations Coordinator**: Delivers operational support, including provider intake, updating demographic information, filing claims, and ensures providers are loaded in the system promptly. They assist with all operational questions including topics such as electronic funds transfer, access to tools, and the provider portal.
- **Claims Analyst**: Works with providers onsite to address escalated claims issues. We also be adding additional support for providers who serve Children with Serious Emotional Disorders (CSED).

We've established a tiered-support structure within our new Provider Support POD model that stratifies provider partners according to their organizational structure and the type of service they provide. This framework ensures that all providers receive comprehensive foundational education and communications, including requirements of the contract and initial orientation while allowing more extensive support for providers with more complex relationships. Layering our program to best serve the array of provider partners enables us to customize the program to the provider's needs. Details of the tiered-support structure include:



- **All providers** – Outreach and engagement with access to regional provider services; tailored education including billing, prior authorization requirements, technical assistance, and prescriber education; claims support and resolution, including first-level triage through claims information research; and interactions with clinical leadership and care management support as needed
- **Rural health systems and hospitals** – Monthly or quarterly Joint Operating Committee with Aetna management; monthly or quarterly in-depth review of provider dashboards, gaps in care and heath equity reporting
- **Large health systems, multi-specialty groups, and behavioral health providers active in value-based programs** – Monthly committee meetings to include operations, quality/care management, community relations; quarterly joint operating and integration oversight executive committee; dedicated provider services and support
- **Specialty behavioral health** – Onsite visits no less than quarterly; specialized provider training and education; follow-up on every inquiry on claims information research to ensure resolution; participation in quarterly joint operating and integration oversight committee

In addition to locally based resources, we leverage our national Medicaid resources that support 16 affiliated Medicaid health plans. This tiered-support structure stratifies providers according to their organizational structure and the services they provide so that we meet providers where they are.

### Provider services helpline

Our provider services helpline is a single resolution source for all providers with questions, concerns, or complaints. To ensure our Provider Services Helpline Team is ready to assist providers, team members undergo training specific to West Virginia Foster Care requirements and health plan policies and procedures. We provide all provider services helpline representatives with two weeks of instructor-led training, online courses, and hands-on practice. Training topics include state-specific requirements, claims handling, appeals, denials, claims edits, and training on our claims system.

Our team is dedicated to responding to provider calls in a timely, accurate, and complete manner. To demonstrate, **as of September 30, 2022, our team answered 1,554 calls, of which 98.33% were answered within 30 seconds**. Our team is equipped to respond to a variety of inquiries about claims status, credentialing, our provider portal, and general information about claims denials and edits. Representatives assist other departments with provider-related issues such as updating demographics, network participation status, and appeals status. We prepare and empower the team to achieve first call resolution for all provider inquiries.

## Innovate to differentiate

**Our model considers the medical, behavioral, SDoH, and health equity terrain of each market, adapts value-based tactics with health delivery teams, and optimizes available tools to reduce the burden of illness and mitigate SDoH and health equity gaps.** These efforts seek to reduce avoidable episodes of care and facilitate the timely provision of services.

We're always looking for new ways to support network providers. We develop innovative solutions by collecting and analyzing utilization data and provider feedback. Aetna staff regularly monitors provider grievances, disputes, complaints, and feedback to identify patterns and develop innovative solutions which support all network providers.

## Digital engagement

We also offer providers several digital engagement tools that align with and support our quality programs to improve member outcomes and provider satisfaction. Aetna Better Health's online provider portal is available 24/7/365 and provides a wide array of program details including the following: all materials and forms providers need to work effectively in the Medicaid program; provider manuals; newsletters; quick reference guides; clinical coverage guidelines and authorization requirements; HEDIS toolkits including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and training documents; preferred drug lists; and a range of search tools to verify enrollee eligibility and claims or authorization status. **Our provider support program is designed to reduce burdens, increase transparency, and give providers the ability to do what they do best—take care of our members.**

| | |
|---|---|
| PS01 | The Vendor should provide initial (during implementation) and ongoing training for new and existing providers.<br>1) The Vendor should explain the proposed process, schedule, and content for providing ongoing training to new and existing providers.<br>2) The Vendor should provide an overall summary of training topics for new and existing providers. |

## Training for new and existing providers

Providers are our most valuable service delivery assets. Our job is to empower them by providing education, assistance, and resources to engage members in their care. **We'll continue to focus our ongoing West Virginia Foster Care, Adoption Assistance, Socially Necessary Services (SNS), In-State Residential Care, and CSED provider training initiatives on helping providers evolve their practices to reduce fragmentation, enhance coordination, and provide individualized care to meet the needs of these children and their caregivers.**

"As a not-so-experienced Case Manager, Aetna's involvement began a journey of organizing myself much better than I had. I met once a week with an Aetna Rep and each week we went over the needs of our kids. This made our process much more efficient, helped me identify where the needs were for the children, and made me a better Social Worker.

Not only that, but Aetna has been an incredible resource to troubleshoot problems with the resident's medications and even their permanency. I am so grateful for the support I received from Aetna and I would highly recommend their services. Aetna brought value to the table, thank you so much for the love and care you have been pouring out onto our kids."

*– Selena Hoye, Program Development Coordinator New River Ranch Children's Home (Fayetteville, WV)*

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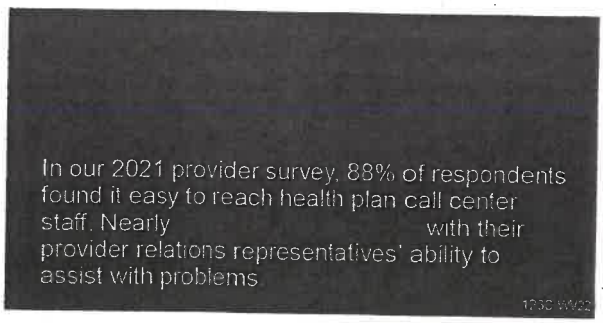
The goal of our provider training program is to support providers and facilities in their effort to deliver high-quality care. Our training program is designed to deliver providers a comprehensive understanding of health plan policy and DHHR requirements at the time of initial contracting and on an ongoing basis. We know some members face challenges that directly impact their ability to receive the appropriate health care services they require. This might be due to limited English proficiency, cultural and social barriers, behavioral health concerns, and physical limitations. We offer providers specialized training and support, emphasizing member accommodation and cultural competency. Through training, complaint resolution, and monitoring member service utilization, we work to ensure members have access to qualified and comprehensive providers regardless of race, gender, age, disability, or geographic location. Our Provider Support PODs are at the forefront of our training, offering onsite visits, policy and plan updates, and ad hoc training reviews for providers who are unable to attend a quarterly or annual training session.

**Our formal initial engagement and orientation practices for newly contracted providers include welcome packets, orientation, one-to-one support, and ongoing education.** Our training sessions and materials emphasize specific topics that are critical to caring for this population, such as trauma-informed care, adverse childhood experiences (ACEs), and CSED.




## Welcome packets

Our welcome packets convey valuable information quickly and in a functional, easy-to-follow format. They include a welcome letter, information about how to attend our provider orientations, how to access our provider manual and provider portal, contact information for their assigned provider services representative, other key contacts, and a copy of their contract.

## Initial training and provider orientation

**To date, in 2022, we trained 227 new West Virginia providers using our new provider orientation process.** New providers receive an overview, a link to our provider manual, information regarding covered services, assessments, authorizations, and claims instructions. Our initial training, including provider orientation begins within 30 calendar days of executing a contract with a new provider. The approach and frequency of each training is illustrated in the table below.

New and existing provider orientations and initial trainings

| Training session | Topics covered | Frequency |
|---|---|---|
| Orientation Part 1: New Provider Orientation | • West Virginia Medicaid overview stressing mandatory reporting requirements under West Virginia Code §49-2-803 (emphasizing increased risk of reportable events for this population); fraud waste and abuse<br>• Provider Information including provider relations and member services functions and contact information; provider website, secure provider portal and provider manual; and provider communications<br>• Covered services including physical health and behavioral health services; dental care; medical prior authorization; authorization timeliness and medical necessity; claims processing (clearinghouse, clean claims, and claim submission); appeal and grievance process; and HEDIS<br>• Standards: Access and availability standards, cultural sensitivity standards (non-discrimination, and reasonable accommodations for members with disabilities), and medical record standards | Monthly & Quarterly Refreshers |
| Orientation Part 2: West Virginia Foster Care, Adoption Assistance, and SNS Orientation | • Provider roles and responsibilities; covered medical, behavioral, and SNS services and the provider's responsibilities for providing and/or coordinating such services, with a special emphasis on areas that vary from Mountain Health Trust and West Virginia Health Bridge Medicaid coverage and commercial coverage rules<br>• The Department, BSS, local child protective services workers, members, foster care, and adoptive parents and how Aetna coordinates and collaborates with these groups<br>• Family First Prevention Services Act, and other federally mandated services and programs impacting covered West Virginians<br>• Continuity of care training that emphasizes HIPAA requirements supporting compliant sharing of member health information and the aging out process, and support available through Aetna | Monthly & Quarterly Refreshers |

| New and existing provider orientations and initial trainings | | |
|---|---|---|
| **Training session** | **Topics covered** | **Frequency** |
| Orientation Part 1: CSED New Provider CSED Waiver Program Overview | • Program goals, requirements, and outcomes<br>• Defining serious emotional disorder<br>• CSED waiver eligibility criteria, application process, plan of care, and becoming a CSED waiver provider<br>• Aetna's responsibilities in the CSED waiver program<br>• Initial medical eligibility criteria<br>• Definition of wraparound facilitation | Monthly & Quarterly Refreshers |
| CSED New Provider Orientation Part 2: CSED Incident Management Systems & Processes | • Incident background, identification, and reporting<br>• Key responsibilities and how to follow up | Monthly & Quarterly Refreshers |
| Requirements for Providing Physical and Behavioral Health Care Services and Dental Care to West Virginia Members | • Medical consent requirements; mandatory reporting requirements under West Virginia Code §49-2-803 (emphasizing increased risk of reportable events for this population); required timelines for services and assessments; performance measures and health outcomes<br>• Methods for and the importance of encouraging members with complex needs to seek PCP services; circumstances when specialty providers may serve as PCPs; opportunities for standing referrals; availability of disease management<br>• American Society of Addictive Medicine criteria, application of the criteria in the assessment and level of care processes, and State oversight and monitoring process<br>• Evidence-based behavioral health treatment interventions and specific behavioral and physical health needs of the Foster Care and Adoption Assistance populations; specific medical information required for children in foster care, appropriate utilization of psychotropic medications<br>• Dental care including training PCPs that beginning at six months after the first tooth erupts or by 12 months of the EPSDT process, the member should be referred to dental providers. This training includes instructions to the PCP to educate the caregiver on the need for dental care.<br>• High Fidelity Wraparound approach; trauma-informed care; crisis intervention services; screening for and identification of trauma, and behavioral health and substance use disorders<br>• Child and adolescent needs and strengths, Impact of Adverse Childhood Experiences; neonatal abstinence syndrome; the effects of abuse and neglect on the developing brain, the effect of intrauterine assault, fetal alcohol syndrome, shaken baby syndrome and substance-exposed infants<br>• Care coordination teams for West Virginia members and how to access the care coordinator | Monthly & Quarterly Refreshers |
| Quarterly Updates Training | • Refresher information related to topics covered during initial provider trainings; changes in policies and requirements; gaps in care reports and provider incentives<br>• Required training on topics such as the application of American Society of Addiction Medicine criteria in the assessment and level of care processes<br>• HEDIS updates for billing and coding<br>• Upcoming prior authorization changes and transition to Availity | Quarterly |
| Annual Provider Forums | • Provider relations and member services functions and contact information; provider website, secure provider portal and provider manual; fraud, waste, and abuse<br>• Authorization timelines and medical necessity | Annually |

| New and existing provider orientations and initial trainings | | |
|---|---|---|
| **Training session** | **Topics covered** | **Frequency** |
| | • Claims processing including clearinghouse, clean claims, claim submission; authorization timelines and medical necessity; appeals and grievances; HEDIS<br>• Access and availability standards and upcoming Medicaid contract changes<br>• Available provider and member incentives; opportunities available for wellness clinic partnerships | |

## Ongoing provider training

**We have conducted 77 ongoing provider training sessions in West Virginia as of October 2022.** These training courses are statewide and include face-to-face town halls, community outreach trainings, online webinars, and one-on-one office visits. This gives providers an opportunity to attend training at a time and through a modality convenient to them and, if applicable, their office staff. Providers are notified of policy and program changes through Provider Support POD team members, provider notices, and updated training programs.

Our ongoing provider training approach and frequency of each training is illustrated in the table below.

| Provider specific trainings | | |
|---|---|---|
| **Training session** | **Topics covered** | **Audience** |
| **Transitioning Youth Training** | • Training and support tools to assist providers and BSS staff in meeting needs of youth in foster care, including those struggling with placement stability<br>• Available behavioral health supports and how to obtain services<br>• Working with Aetna care coordinators | Providers and BSS staff |
| **Sex Trafficking 101** | • Training developed with West Virginia law enforcement on human trafficking and the complex behavioral health needs of this population | New and Existing Providers |
| **Foster, Adoptive, and Kinship Training Series** | • Quarterly topics identified through Governance Board/ stakeholder feedback and can include:<br>• Trauma-informed care overview<br>• Trauma-informed care deep dives: working with children in crisis; compassion fatigue and caregiver self-care; supporting children in congregate care; children with fetal alcohol syndrome and substance exposure | New and Existing Providers |

## Provider and stakeholder forums

Our training program is designed around interdisciplinary learning and community collaboration, creating a transparent and collaborative whole-health care advocate team. Providers, behavioral health providers, members, family members, system partners, our staff, and a multitude of valued stakeholders can participate in cross-disciplinary learning through ongoing training events.

The table below reflects examples of the types of provider and stakeholder forums we offer:

| Provider and stakeholder forums | | |
|---|---|---|
| **Forum** | **Topics covered** | **Frequency** |
| **Foster Care Behavioral Health Navigation Forum** | Opportunities for providers and foster, adoptive, kinship, and group home caregivers to learn about the behavioral health services available to children and youth in foster and adoptive care. | Monthly |
| **Child and Family Advisory Partnership** | These forums allow foster, adoptive, kinship, and group home caregivers to connect with the local behavioral health community and | Monthly |

| Provider and stakeholder forums | | |
|---|---|---|
| **Forum** | **Topics covered** | **Frequency** |
| **Community Forum** | speak directly with providers. Attendees are encouraged to share ideas on how to improve care delivery for members and their families. | |

## Trauma-informed care training

We leverage our strong West Virginia provider relationships to collaborate with providers in ways that improve clinical management of chronic illness, test models of care to transform care, and offer trauma-informed and person-centered support to members.

Children in the Mountain Health Promise plan experience higher rates of trauma than other Medicaid populations. We offer training on providing trauma-informed care and incentives for providers who complete it.

We've trained providers throughout West Virginia in trauma-informed care via in-person and virtual sessions. Many more providers have accessed our trainings posted on our public facing provider website. **Our goal is to have 100% of the providers who serve Specialized Managed Care for Children and Youth to adopt the trauma-informed care model.**

Providers who complete trauma-informed care or cultural competency training can opt to have these indicated in our provider directory. These "flags" help our member services staff direct members to providers trained in these areas.

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| PS02 | The Vendor should provide training to providers regarding mandated reporting to comply with applicable State Code, including, but not limited to, WV Code §49-2-803, as defined by the Agency.<br><br>The Vendor should describe how it will meet this specification.<br><br>Information regarding WV Code §49-2-803 can be found at the following location: https://code.wvlegislature.gov/49-2-803/ |

## Suspected abuse and neglect training

Provider trainings include education on medical consent requirements and mandatory reporting requirements under West Virginia Code §49-2-803, with an emphasis on the increased risk of reportable events for this population. Our provider manual, provider website, and Provider Support PODS are utilized to communicate to providers their responsibility concerning the mandatory reporting requirement under West Virginia Code §49-2-803. **To date in 2022, we have conducted 10 suspected abuse and neglect trainings with CSED providers**. These trainings included the following topics: identifying the incident, reporting the incident, key responsibilities, and incident follow-up.

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| PS03 | The Vendor should coordinate with the member's primary care provider (PCP) and behavioral health provider, for populations eligible for medical services, to ensure each provider has access to the most up-to-date medical records.<br><br>The Vendor should describe how it will meet this specification. |

## Access to up-to-date medical records

We coordinate with each member's PCP and behavioral health provider to ensure each provider has access to the most up-to-date medical records. **We understand the importance of having accurate, update to date medical information for providers who are helping coordinate care for this**

**complex population.** We offer PCPs and behavioral health providers several tools to access electronic medical records, consistent with privacy laws and disclosures. These tools include:

- **Provider website:** Our provider portal offers online as well as ongoing support, and includes the provider manual, newsletters, forms, clinical guidelines, and other support resources. Our secure portal offers self-service tools such as access to our online provider directory for referral information and our provider orientation presentation. Additional provider portal details are described in response to PS13.
- **FamilyConnect 2.0 care management portal:** The program includes non-traditional providers, like residential treatment providers, which do not have a direct contract with Aetna, but are part of a child's care coordination. FamilyConnect 2.0 serves as the single source of truth for youth and caregivers. The portal contains copies of current and prior assessments, actionable information, and care plans, as well as the information previously included in the Medical Passport, a tool utilized by the foster care community. We work with the DHHR to identify these professionals and their assigned member rosters to ensure privacy and regulatory compliance is met. FamilyConnect 2.0 training is available to these individuals.
- **Availity provider portal:** We leverage our Availity provider portal to deliver robust self-service and online tools, allowing providers to easily navigate our policies, procedures, and requirements. Availity allows providers to directly communicate with our clinical and administrative staff through the "Contact Us" application. Additional provider support capabilities offered through Availity include the ability for providers to:
  - Review precertification requirements, submit/modify authorizations, and monitor status
  - Submit specialty pharmacy prior authorizations
  - Look up member eligibility, benefits, and claims
  - View member risk assessments and care plans, practice guidelines, HEDIS documentation, and quality improvement activities
  - Access Electronic Funds Transfer and Electronic Remittance Advice forms
  - Submit grievances and appeals

We continue to participate in the West Virginia Health Information Network and encourage network providers to participate during new provider orientation. **We also offer technology grants to support participation by independent or rural provider's in accessing the platforms.** Additional Availity provider portal details are described in response to PS14.

| | |
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| PS04 | The Vendor should establish a five-star, quality rating system for its contracted providers and disseminate this information to help members make informed choices about their care.<br><br>The Vendor should describe how it will meet this specification, including an approach to establishing quality ratings and how the Vendor will disseminate the information. |

## Five-star quality rating system

The public health emergency (PHE) limited the provider's ability to see members, impacting their ability to collect and report HEDIS measures. Any data collected during the PHE would have been skewed negatively impacting provider quality ratings. Due to this difficulty, the requirement to establish a five-star quality rating system was waived. Once the PHE is lifted, Aetna will quickly implement and establish a five-star quality rating system for its contracted providers.

Aetna utilizes provider and member information to determine the measures included in the quality ratings system, which is comprised of a combination of key indicators from several data sets, including:

- HEDIS scores
- Attestation to completing education

## Dissemination to members

Our member services staff helps guide members to high-quality or specially trained providers. Five-star quality ratings are also explained in the member handbook and provider directory.

Our provider directory will display providers' five-star quality rating next to their name. **Our current provider directories already display additional competency indicators, such as when a provider has completed training in adoption competency and/or cultural competency training.**

We continue to work collaboratively with DHHR and West Virginia providers to create additional opportunities to recognize and feature those providers with demonstrated high-quality services and qualifications that address issues experienced by children in the Specialized Managed Care for Children and Youth program.

| | |
|---|---|
| PS05 | The Vendor should distribute provider manuals according to timeframes and methods of delivery approved by the State.<br><br>The Vendor should describe how it will meet this specification, including suggested timeframes and methods of delivery. |

## Provider manuals

We ensure each provider is issued a printed or electronic copy of the provider manual during the contracting process. Once the provider is in network, during our orientation process they receive a welcome packet and access to the provider manual online. We also provide a hard copy of the provider manual upon request. **The provider manual serves as a guide to the policies and procedures governing the administration of our network** and includes the following topics:

- Program benefits and limitations
- Claims filing instructions
- Criteria and process to use when requesting prior authorizations
- Cost-sharing requirements
- Definition and requirements about urgent and emergent care
- Members' rights
- Providers' rights for advising or advocating on behalf of his or her patient
- Provider non-discrimination information
- Policies and procedures for grievances and appeals
- Contractor and DHHR contact information such as addresses and phone numbers
- Policies and procedures for third party liability and other collections
- Training
- Credentialing
- Utilization management
- Timeliness and availability standards
- Data reporting
- Basic population health management
- Care coordination for non-covered services

We update our provider manuals at least once per year. Feedback from key stakeholders and committees inform the provider manual's development and clarify new or revised policies and procedures. We notify providers of revised policies and procedures through provider bulletins, or

provider website, and email/fax blasts. As an additional measure, **Provider Support POD team members contact providers and confirm providers received, understood, and implemented required policy and procedure changes.**

When there are DHRR policy or program changes or Aetna procedure or service site changes, we notify the affected providers at least thirty calendar days before the intended effective date of the change.

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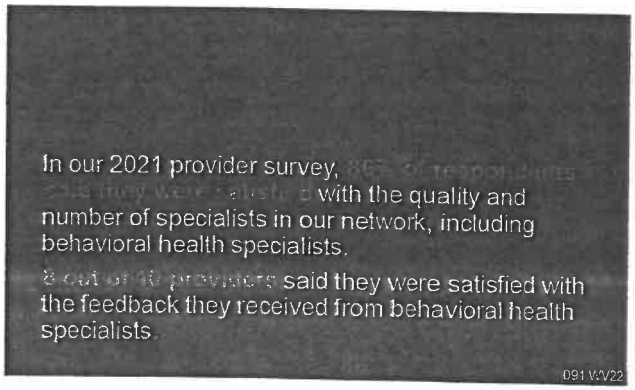
| PS06 | **The Vendor should accept and pay claims on time for physical and behavioral health services, as defined by Appendix 3: Service Provider Agreement (SPA). The Vendor should describe how it will meet this specification. The response should include, but is not limited to:**<br>• **A breakdown of turnaround times for paper vs. electronic data interchange (EDI) claims**<br>• **Claim turnaround report for each of the past 12 months, indicating the percentage of total claims that are clean, and the percentage of clean claims processed within 30 days and within 90 days**<br>• **Claim payment timeliness is defined in Appendix 3: Service Provider Agreement (SPA) for Mountain Health Promise.** |

## Timely claims payment

We are committed to meeting and exceeding the State's requirement to pay clean claims within 30 days of receipt. We understand that timely and accurate payments reduce provider abrasion and increase provider satisfaction. **Year to date, our 12-month rolling electronic claims submission rate was 95%. Of the 538,000 Mountain Health Promise claims received in 2021, 91% were auto adjudicated.** In support of these requirements, we generate a weekly payment cycle for medical claim payments.

We continue to accept and pay claims on time for physical and behavioral health services, as defined in Appendix 3. We accept claims in both electronic and paper form.




We continually improve our systems to align with the DHHR's requirements through transparent communication, responsible stewardship, and collaboration with DHHR. Our claim processing system is highly customizable and flexible, which allows us to configure our systems in accordance with West Virginia's fee schedules, covered services, and provider manual requirements. This also allows us to respond quickly to the needs of the State when off-cycle updates occur in health plan advisories, information bulletins, and ad hoc requests. **As of September 30, 2022, our auto-adjudication rate for West Virginia Foster Care is 70.9%.**

The table below lists our consistently high-performance data and compliance with timely processing surrounding 30-day claims payment requirements for the last 12 months.

| | Days to Pay | | 30 Days | | 90 Days | |
|---|---|---|---|---|---|---|
| Month | EDI Claims: Average Days to Pay | Paper Claims: Average Days to Pay | Total Claims Processed in 30 Days | Percent of Claims Processed in 30 days | Total Claims Processed in 90 Days | Percent of Claims Processed in 90 Days |
| Oct-21 | 9 | 11 | 46,694 | 99.52% | 46,874 | 99.91% |
| Nov-21 | 9 | 10 | 51,307 | 99.82% | 51,402 | 100.00% |
| Dec-21 | 9 | 12 | 50,251 | 99.78% | 50,362 | 100.00% |
| Jan-22 | 9 | 12 | 37,252 | 99.69% | 37,366 | 99.97% |

| | Days to Pay | | 30 Days | | 90 Days | |
|---|---|---|---|---|---|---|
| Month | EDI Claims: Average Days to Pay | Paper Claims: Average Days to Pay | Total Claims Processed in 30 Days | Percent of Claims Processed in 30 days | Total Claims Processed in 90 Days | Percent of Claims Processed in 90 Days |
| Feb-22 | 9 | 11 | 47,613 | 98.16% | 48,502 | 99.99% |
| Mar-22 | 8 | 12 | 53,066 | 99.08% | 53,410 | 99.73% |
| Apr-22 | 9 | 11 | 47,303 | 98.38% | 47,731 | 99.27% |
| May-22 | 8 | 13 | 54,190 | 98.94% | 54,767 | 99.99% |
| Jun-22 | 9 | 13 | 37,569 | 98.22% | 38,225 | 99.94% |
| Jul-22 | 9 | 14 | 40,522 | 90.00% | 44,873 | 99.66% |
| Aug-22 | 9 | 15 | 57,958 | 96.75% | 59,878 | 99.96% |
| Sep-22 | 9 | 13 | 41,396 | 97.24% | 42,409 | 99.61% |

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| PS07 | The Vendor should establish and implement a review process for payments for emergency services for populations eligible for medical services including, but not limited to, which types of claims are automatically paid and pended, evaluation of pended claims for payment, and upholding the "prudent layperson" standard as defined by Appendix 3: Service Provider Agreement (SPA).<br>1) The Vendor should describe how it will meet this specification.<br>2) If algorithms are used to evaluate pended claims, the Vendor should describe how it will ensure that the "prudent layperson" standard is upheld.<br>West Virginia Prudent Layperson standards are defined in Appendix 3: Service Provider Agreement (SPA) for Mountain Health Promise. |

## Emergency services payment review

**We never require prior authorization for emergency care.** Aetna pays all claims for emergency services and limits the pending of emergency claims to those situations where a provider is identified as an outlier in billing services with higher levels of codes compared to similar providers. The emergency department records associated with the claims are then reviewed against current emergency department coding guidelines. Claims are paid based on place of service, services provided, and level of care, not the member's symptoms or final diagnosis, ensuring appropriate reimbursement for the services rendered.

We support the state's goal and have programs in place to **limit avoidable use of emergency services**, including provider trainings and monthly joint operating committee meetings with primary care providers. During those meetings, "frequent utilizer" reports are shared, and strategies and best practices discussed.

Care managers work with members to educate them on where to go for primary care, same day urgent care, behavioral health crises, and emergency services. **Aetna believes that care management is a successful tool to reduce emergency department utilization. Internal analysis shows a 46% reduction in children with 6 to12 months of care management.**

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| PS08 | The Vendor should educate and provide guidance to primary care providers (PCP) on coordinating physical health services and ensuring that the primary care provider (PCP) coordinates the member's physical health services, as appropriate, with behavioral health and/or socially necessary services (SNS) for populations eligible for medical and SNS services.<br><br>The Vendor should educate primary and specialty care physicians about foster care members and members with complex needs, including, but not limited to, opportunities for standing referrals, opportunities for specialists to serve as PCPs, and availability of disease management.<br><br>The Vendor should describe how it will meet this specification. |

## Primary care provider education and guidance

Our orientation trainings include an overview of Medicaid and SNS covered services and describing practices for coordinating member care. Our CSED provider trainings also emphasize the need to coordinate care. Due to the complex social and health needs and the experiences this population faces, our PCP training is broad in scope and emphasizes individualized, whole person approaches to primary care and services.

We educate PCPs on the spectrum of behavioral health treatments and services available, including intensive in-home and facility-based interventions for Children with Serious Emotional Disorders, how to coordinate with non-traditional providers, member's assumed kin, local department case managers, community supports, and resources and supports available through Aetna. **The latter include our locally based clinical care teams, member and provider helplines, and online resources which is used to assist in identifying and connecting members to services.**

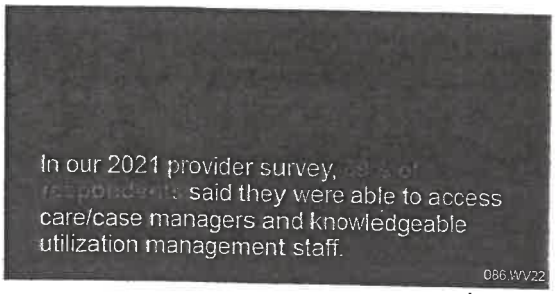
It is important for network providers to understand how social care needs play into member health outcomes. With this knowledge, providers can support members in meeting social care needs. To better prepare providers, we begin by assessing their current practices for identifying and addressing those social needs. After ensuring providers are prepared to identify and address them, we encourage providers to communicate the information to us using SDoH. We use SDoH to identify value-added programs and other social supports and populations in need. Providers are educated on social care best practices and the many available services they can leverage (e.g., the Social Care Team, our call center focused on social needs) to ensure all member concerns are adequately addressed.

Online resources are also available through the provider website and secure portal and include key contacts, eligibility requirements, and requirements related to services for children in foster care, such as circumstances where BSS representative consent is required. Monitoring of provider compliance with care coordination is through our quality management program.

## Education on foster care members and children with complex needs

All members of this population are assigned a care manager because of their complex needs. We educate PCPs about working with the care manager to assist in arranging for services.

We educate network providers regarding the availability of complex care management, disease management and member-level risk mitigation during initial and ongoing training.



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| PS09 | The Vendor should educate primary care providers (PCPs) about the importance of dental screenings to ensure appropriate referrals to dental providers, including, but not limited to, training PCPs that beginning at six (6) months after the first tooth erupts or by 12 months of age (as part of the Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] process), the member should be referred to dental providers. This training should include instructions to the PCP to educate the caregiver on the need for dental care.<br><br>The Vendor should describe how it will meet this specification. |

## Dental screenings




We provide specific training to PCPs regarding the importance of dental screenings and the appropriate referral process to dental providers, including, but not limited to, training PCPs that beginning at six months after the first tooth erupts or by 12 months of age, the member should be referred to a dental provider. (See tables in PS01). Training materials related to dental EPSDT services include input from our dental director to make sure materials are accurate and consistent with training and education offered by SKYGEN, our dental subcontractor.

SKYGEN is currently conducting a statewide training for all West Virginia dental providers in its network about requirements related to dental screenings and services. The training also provides an overview of SKYGEN and our integrated care management program, through which EPSDT eligible members, parents, foster care parents, and legal guardians are notified of dental EPSDT services.

SKYGEN actively promotes family involvement in using dental home EPSDT services and conducts member outreach to encourage families to ensure children are receiving comprehensive, age-appropriate dental services. Member outreach for the Special Managed Care for Children and Youth program includes phone calls and mailings, as well as tip sheets for distribution at PCP and other provider offices, local service agencies, health clinics, and other community-based health care locations.

In 2023, we intend to conduct a dental RFP to improve quality and network offerings for members.

| | |
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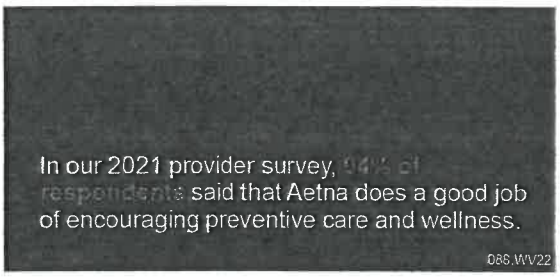
| PS10 | The Vendor should educate and monitor primary care providers (PCPs) regarding administration of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.<br><br>The Vendor should describe how it will meet this specification. |

## EPSDT services




Aetna provides specific training to PCPs regarding the importance of EPSDT screenings and appropriate referral process. Our training educates providers on the American Academy of Pediatrics standards of care and reviews the process for referring members to specialists, including behavioral health providers.

EPSDT services are fundamental to identifying developmental, physical, and behavioral issues. While EPSDT services are critical for all children in Medicaid, children involved in the foster care system and adoption assistance programs are at higher risk for experiencing trauma and missing key screenings. As a vital first step to ensuring these vulnerable children receive all necessary services, we inform members and their caregivers of their

right to receive EPSDT services. We train PCPs on our expectations for compliance and provide information about the West Virginia EPSDT Periodicity Schedule, including the requirement to perform oral health assessments, evaluations, prophylaxis, and oral hygiene counseling.

We educate providers on referring members to dental care, conducting routine physical examinations including comprehensive unclothed physical examinations, screenings for developmental delay through the fifth year, autism spectrum disorder, and appropriate immunizations, laboratory testing, and health education. Educational activities emphasize the importance of the use of validated developmental screening tools, the expectation that providers will assist families with scheduling appointments for EPSDT visits, and any additional assessments, referrals, and follow-up. This includes following up with families whose children missed their screening visits.

Children in foster care and at-risk youth are more likely to miss appointments due to a variety of factors, including changes in member placements, member unwillingness and/or hesitation to receive services, and transportation challenges. As a part of PCPs' training, we include information on solutions to improve member participation and reduce no-show/missed appointments. These strategies include working with the member's Aetna care coordinator, provider outreach to the member and their caregivers, and provider support tools to assist with resolving members' barriers to care. **In 2023, under our new Provider Support POD model, Provider Support Representatives, Provider Operations Coordinators, Claim Analysts, and Quality Practice Advisors will be available to assist providers struggling to conduct appropriate EPSDT screenings and address gaps in care.**

Our training educates PCPs on Aetna's monitoring and compliance process. We conduct monthly and quarterly analyses of EPSDT screening and well-visit rates. This routine monitoring is used to help identify strategies that are working well and provides insights into areas for improvement. Aetna's clinical care teams review gaps in care using HEDIS tool kits and gap in care reports. Quality practice advisors are responsible for conducting outreach to parents, caregivers, and legal guardians of members ages 0 to 20. We track EPSDT requirements and HEDIS measures and utilize the data to generate reports and identify any early deficiencies.

Through our efforts, we have increased EPSDT scoring as demonstrated in the table below.

| | Year over year improved increase | | |
|---|---|---|---|
| EPSDT | 2020 | 2021 | 2022 |
| Immunization for adolescents | 34.9% ↑ | 15% ↑ | 41.8% ↑ |
| Childhood immunization status combo 2 | 19% ↑ | 1.9% ↑ | 17.3% ↑ |
| Childhood immunization status for combo 3 | 15.5% ↑ | 1.9% ↑ | 16.2% ↑ |

## EPSDT profiles

To create EPSDT profiles, we use gap in care reports in Availity, quarterly measures, and incentive programs. We share the pediatric measures with network providers quarterly for quality improvement purposes and generate these profiles for each provider or practice to include items such as well-visit rates and well-visit components.

## EPSDT incentives

We send providers quarterly gap in care reports that identify children who are due for, but have not yet received, a well-child visit. **If providers succeed in delivering a well-child visit to a child identified**

**on the gaps in care report, they are eligible for a $25 incentive payment per claim.** These payments are made quarterly.

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| PS11 | The Vendor should educate providers about the ability to request out-of-network referrals. The Vendor should describe how it will meet this specification. |

## Out-of-network referrals

EPSDT screenings for high-needs populations, including children involved in the foster care and adoption assistance populations, may result in identification of needs for specialty providers or circumstances that are more likely to require access to out-of-network providers. Through our new orientation trainings, periodically in our quarterly trainings, and available any time through our online provider portal, we educate providers on Aetna's policies and practices for obtaining out-of-network referrals.

We approve referrals to out-of-network providers if the services are covered and medically necessary, but an in-network provider is not available. The approval process is quick, adding no additional burden to the referring PCP. We work with out-of-network providers to encourage them to join our network or enter into a single-case agreement with us so that the member can access services.

We educate network PCPs on our role in coordinating services with out-of-network practitioners in a timely manner, the type of information we provide to members to arrange for approved out-of-network services, and our process for ensuring members do not incur any additional cost for these services.

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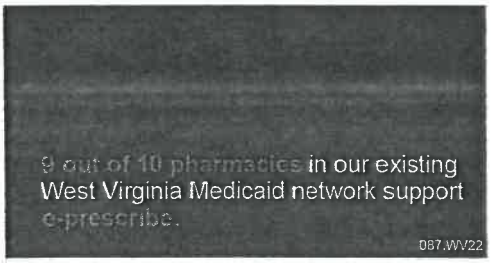
| PS12 | The State does not currently have plans to carve in point-of-sale pharmacy. However, should these services be carved in at a future date, the Vendor should support e-Prescribing functions.<br><br>The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date. |

## e-Prescribe

The Aetna-Caremark PCS pharmacy network supports the use of electronic prescribing (e-prescribe) tools to ensure efficient and safe access to covered medications.

Review of pharmacies in the Aetna-Caremark PCS pharmacy network, shows that **538 pharmacies serving West Virginia Medicaid currently support e-prescribe.**




Our website provides access to our e-prescribing tool through a web link. Our e-prescribe tool allows providers to see the preferred drug status, therapeutic alternatives, and clinical criteria on the selected medication (i.e., prior authorization, step therapy, quantity limits). Nationally evidenced, electronic prescribing has proven to be a safer and more efficient way of communicating prescriptions between providers and pharmacies. Our e-prescribe tool, which is widely used by network providers, improves prescribing efficiency and safety. **Currently, Aetna Medicaid prescribers send 75.8% of prescriptions to our pharmacies via e-prescribe. The rate is even higher for our behavioral health providers at 87.5%.**

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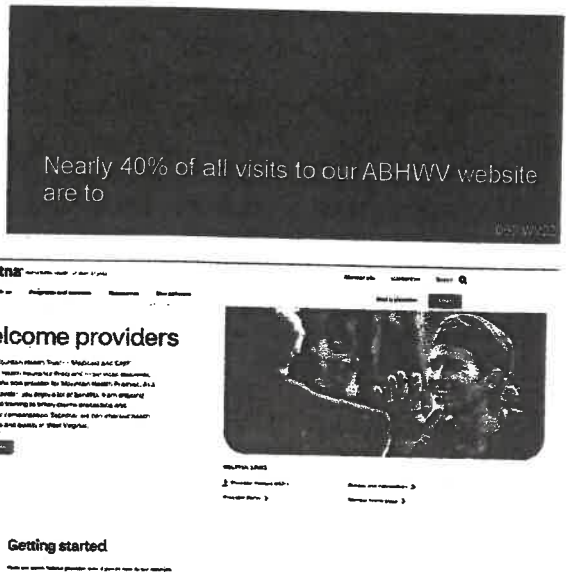
| PS13 | The Vendor should provide a publicly accessible, secure website with information targeted to providers.<br>The Vendor should describe how it will leverage its website to help meet the needs of providers. |

## Public-facing provider website

Aetna provides a publicly accessible, secure website with information targeted to providers and can be found at www.aetnabetterhealth.com/westvirginia/providers/index.html.

Information available on our publicly accessible provider website includes:

- Contact information for our call centers and hotlines, including the provider helpline
- Searchable provider manual and provider directory
- Prior authorization requirements
- Pharmacy preferred drug list and pharmacy conditions for coverage and utilization limits
- Information on member rights and responsibilities
- Provider updates
- Links to other websites, including the DHHR website and BSS website




In 2023, we are adding a foster care component to our website. The foster care component will include educational information related to working with foster care children, the Specialized Managed Care for Children and Youth program, and other informative materials.

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| PS14 | The Vendor should provide a secure portal--accessible by providers, Agency caseworkers, caregivers, and other stakeholders as permitted by the Agency--that allows these stakeholders to log in and access information as permitted by the Agency, including, but not limited to, medical records, authorization status, and confirmation of services previously provided to avoid duplication.<br>The Vendor should describe how it will leverage its website to help meet the needs of providers, Agency caseworkers, and other stakeholders as permitted by the Agency.<br>Note: The Medicaid fiscal agent will provide member eligibility information. |

## Secure provider portal

We leverage the Availity provider portal to provide robust self-service and online tools to allow providers to easily navigate our policies, procedures, and requirements. Availity also allows providers to directly communicate with our clinical and administrative staff through the Contact Us application. Availity offers secure single sign-on functionality and access for providers to:

- Search member eligibility and verify enrollment
- Search claims status and claim detail
- Submit claim reconsiderations
- Submit appeals
- View remittances
- Search for member identification (ID) cards and panel rosters
- View the status of a member's compliance with HEDIS measures

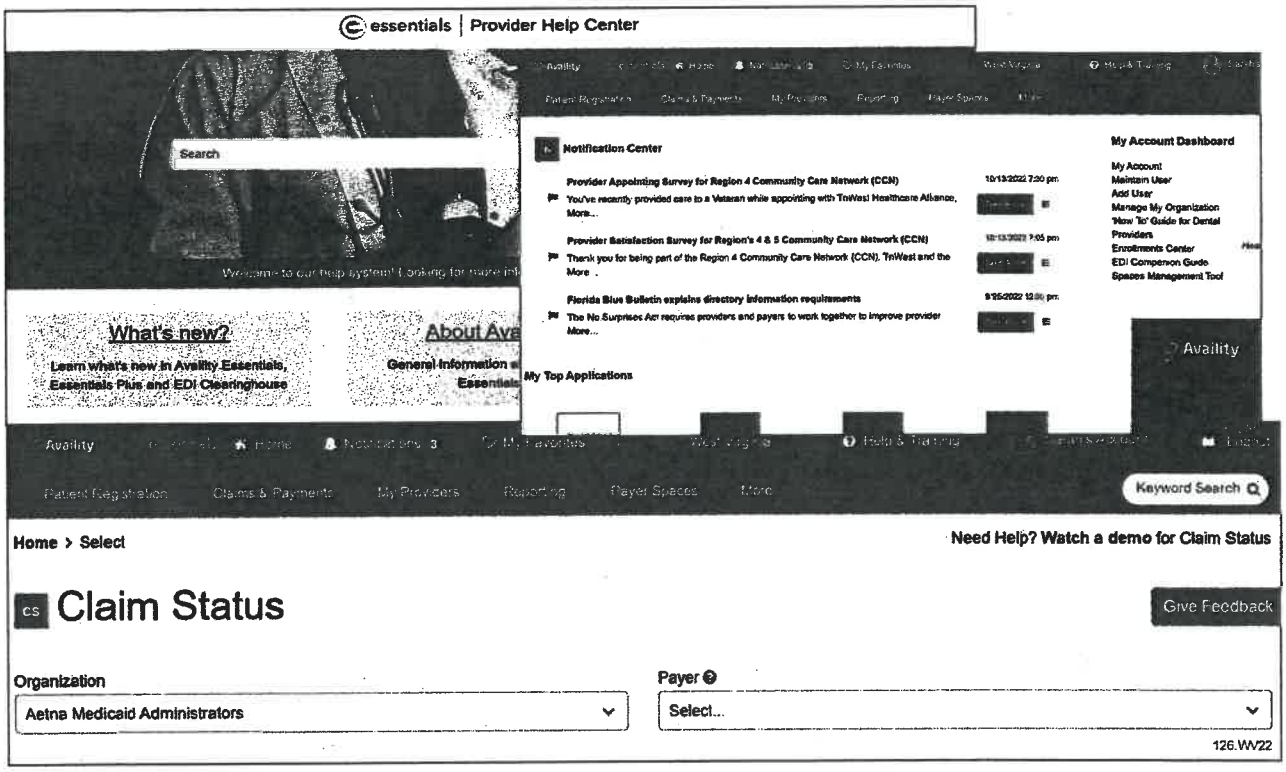


***Figure E.6-2**: Examples of Aetna's Secure Provider Portal - Our secure provider portal is designed to make information available for our providers in an easily accessible manner and at the provider's convenience.*

- Utilize the prior authorization lookup tool designed to perform ID-specific searches for authorizations by member and provider, including authorization data, or submission/service dates, while allowing for review of prior authorization requirements by specific procedures or service groups and showing details on codes and any noted prior authorization exception information

We continually review and identify opportunities to improve the functionality and ease of use on our provider portal and respond to changing program needs.

**Access to member information is particularly critical for providers who are treating children and youth in this population because children often present for an appointment with no medical history, especially after a change in placement or following a recent revocation of parental rights.** To further support timely access to information and coordination of care, we also provide access to the secure provider portal to DHHR caseworkers and other stakeholders, consistent with applicable federal and state privacy security laws, regulations, and standards upon request.

Our system is designed to support a variety of user roles. We collaborate with the DHHR to assess and identify user roles and needs to support compliance with role-based permissions.

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| **PS15** | The Vendor should provide training to ensure an integrated Vendor Care Plan is jointly developed and shared among the primary care provider (PCP) and/or specialist serving as a principal coordinating physician, and the child and caregiver(s).<br><br>The Vendor should describe how it will meet this specification including how the training will be administered. |

## Vendor care plans

We provide training to ensure an integrated vendor care plan is jointly developed and shared among the PCP and/or specialist serving as a principal coordinating physician, and the child and caregiver(s).

Our integrated vendor care plan process is communicated via our provider and member manuals. Members of our Provider Support PODs are available to provide any additional integrated vendor care plan training and answer all provider questions.

FamilyConnect 2.0 enables a child's care coordinator to utilize information gained through the assessment process to confirm which care management tier best meets the needs of the foster child and assigns them to the appropriate tier. The screening and assessment process lays the foundation for the creation of the initial care plan. Ongoing screenings and assessments continue throughout enrollment. Screenings and assessments are repeated annually, at a minimum, or as triggered by a change in the child, youth, or young adult's functional or health status, or a change in their placement or residence.

Our care managers develop care plans in coordination with members, caregivers, and providers. While developing care plans, care managers communicate with members ensuring that each member has a voice in their individual care plan. **When developing a care plan, a member's goals are our top priority.** Before finalizing a member's care plan, the care manager shares a copy of the care plan with the member's PCP for review, feedback, and approval. After the member's PCP signs off on the care plan, a copy of the care plan is shared with the member, caregivers, and all providers, including behavioral health providers, involved in the member's care.

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| PS16 | The Vendor should work with the Agency and community partners to increase capacity for those services and resources identified as not available in the state.<br>The Vendor should describe its method for identifying services and resources not available in the State and the strategy for increasing capacity in these areas. |

## Identifying gaps

Our **Better Together SDoH Program** works every day to understand gaps in social care resources in the communities we serve. We use a boots-on-the-ground approach to collaborating with social care agencies by bringing on local employees who have lived experience.




In November 2022, we are enhancing our stakeholder feedback process even more by convening **Community Health Councils** in McDowell County. These will be comprised of local community and provider partners including MountainHeart Community Services, Inc., Children's Home Society of West Virginia, and others, serving to help us identify gaps and develop community-owned solutions.

We use a variety of quantitative methods to identify gaps in social services. We use our **Community Resource Directory** (our proprietary social care referral platform) to identify the most common types of social care referrals, which resources our members use most frequently, and whether sufficient resources are available in those locations. We use this information to better understand the West Virginia social safety net and build additional capacity where need dictates.

Our **SDoH risk stratification platform** uses data visualization to create "heat maps" that identify areas of the state at highest risk for social care needs. We also can add additional data layers on top of these maps.

Our platform quantifies the following areas for **community risk** on a risk scale of one to five:

- Economic climate (cost of living, median income, household size)

- Food landscape (food deserts, SNAP eligibility and utilization, food budgets)
- Housing environment (economic stability, household size, rent/own ratios, climate)
- Transportation network (distances to health resources, vehicle ownership, work-from-home)
- Health literacy (income, languages spoken at home, time in the United States)
- Digital landscape (broadband availability, internet costs, computer/smartphone ownership, income)
- Social connectedness (age, environmental factors, gathering locations, physical and mental well-being)

The platform also drills down to **individual risk** using the same five-point scale:

- Financial strain (assets, liabilities, opportunities)
- Food insecurity (accessibility, affordability, literacy)
- Housing instability (crowding, quality, stability)
- Transportation barriers (access, health resource density, mobility issues)
- Health literacy (culture, demographics, education)

## Collaborating with DHHR and community partners to increase capacity

Our Better Together teams partner with existing community organizations to increase capacity and resources including community-based organizations in high-risk areas after a gap or potential gap is identified. For example, to address housing insecurity, Aetna partnered with the Charleston Housing Authority, Workforce WV, and the Division of Rehab. The area from Eleanor to Amma is a combined service area of these organizations. The map that follows (see figure E.6-3) demonstrates that members in this region experience extremely elevated risk for housing insecurity. Our outreach in this region included distribution of wellness and health literacy information and school outreach. Our combined efforts impacted over 100 families.

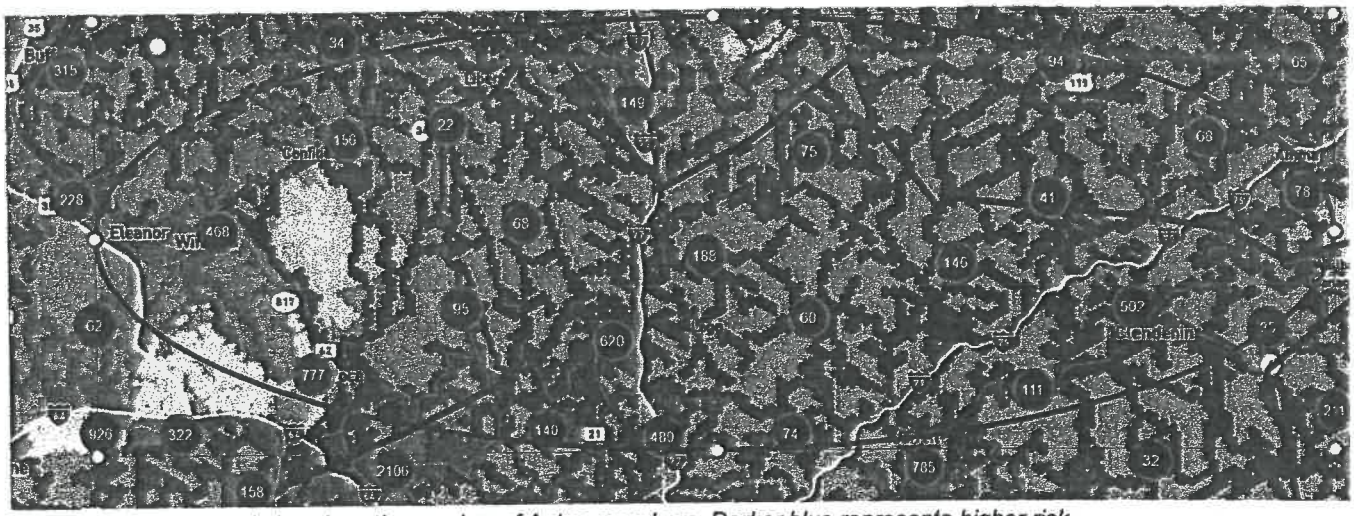


***Figure E.6-3**: Purple circles show the number of Aetna members. Darker blue represents higher risk.*

**We also use this data to identify communities that are excelling at providing community resources so that we can share their strategies to increase capacity with other parts of the state.**

## 7. Quality

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| QU04 | The Vendor should make progress toward and by the commencement of the third year of the contract, earn and/or maintain the NCQA Health Equity Accreditation or the NCQA Health Equity Accreditation Plus. https://www.ncqa.org/programs/health-equity-accreditation. The Vendor should describe its willingness and capacity to earn and/or maintain the NCQA Health Equity Accreditation or the NCQA Health Equity Accreditation Plus. |

Aetna Better Health® of West Virginia (Aetna) commits to health equity. Our experience enables us to obtain health equity accreditation by the beginning of the third year of the contract. **We intend to build upon our recently upheld 4.0 STAR NCQA rating** (achieved in September 2022) and are collaborating with our State partner to obtain the necessary information to achieve this additional distinction from NCQA. Of note, our affiliate, Aetna Better Health of Michigan, a Medicaid product, was one of nine health plans invited by NCQA to participate in the Health Equity Plus accreditation pilot. Through this pilot, the Michigan health plan achieved the Health Equity accreditation with high scores. They received a score of 100% on Health Equity Accreditation and a score of 91% on Health Equity Plus Accreditation. We are currently leveraging their experiences and lessons learned with data collection, standardized processes, and best practices related to program implementation as we earn our health plan's Health Equity accreditation.




### Quality improvement

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| QU05 | The Vendor should administer a Quality Assurance and Performance Improvement (QAPI) Program. This includes participation in multi-year Performance Improvement Projects (PIPs) focused on both clinical and non-clinical areas. The Vendor should describe how it will meet this specification. The Vendor should describe how they determine key performance indicators it will use to measure clinical and non-clinical outcomes and their frequency of review. The Vendor should also indicate how these outcomes will be used to prioritize PIPs. |
| QU10 | The Vendor should monitor quality improvement strategies with measurements including, but not limited to:<br>• Statewide availability and access to care<br>• Timeliness of care<br>• Coordination of care<br>• Demand for services<br>• Quality of care<br>• Health and functional outcomes<br>• Provider workforce<br>• Member satisfaction<br>The Vendor should describe in detail how it will meet this specification. |
| QU12 | The Vendor should collect and analyze quality measures at a set frequency determined by the State. See Appendix 3: Service Provider Agreement (SPA) for an initial inventory of required reports for the program. These requirements may be adjusted by the Agency, as needed, based on the needs of the program. The Agency may request, at no additional cost to the State, that the Vendor provide raw data at a child level directly to the State at a frequency to be determined by the Agency. The Vendor should describe how it will meet this specification. The Vendor should include frequency of screening for appropriate member coordination stratification |
| QU17 | The Vendor should initiate data-driven clinical initiatives that yield improvements in clinical care. The Vendor should describe: 1) Data-driven clinical initiatives that the Vendor initiated within the past 24 months that have yielded improvement in clinical care; 2) Statistically significant improvements generated by these clinical initiatives; 3) Key performance indicators used to evaluate quality and outcomes. |
| QU23 | The Vendor should establish, implement, and periodically enhance ongoing quality and outcomes monitoring activities to ensure quality for members and compliance with program requirements. 1) The Vendor should describe how it will meet this specification; 2) The Vendor should describe when it will perform quality initiative monitoring activities. |

| | |
|---|---|
| QU11 | The Vendor should analyze utilization data to monitor quality improvement strategies. The Vendor should describe in detail how it will meet this specification. |
| QU03 | The Vendor should act against physical and behavioral health providers that demonstrate unacceptable performance. The Vendor should also share identified Socially Necessary Services (SNS) provider performance deficiencies with the Agency. 1) The Vendor should describe the standards it uses to assess provider performance. 2) The Vendor should describe how it will meet this specification, as well as any other ways it would actively work with network providers to ensure accountability and improvement in the quality of care provided. |
| QU16 | The Vendor should develop and implement a process to address quality issues, including, but not limited to:<br>• What steps will be taken<br>• Who is responsible for addressing issues<br>• Time frames for resolution<br>The Vendor should describe in detail how it will meet these specifications. |
| QU02 | The Vendor should share best practice methods or programs with physical and behavioral health providers and provide identified best practice methods or programs to the Agency for consideration in sharing with SNS providers. The Vendor should describe how it will meet this specification, as well as any other ways it would actively work with network providers to ensure accountability and improvement in the quality of care provided. The Vendor should describe which best practice methods it employs to its provider network. |
| QU15 | The Vendor should develop, update, and disseminate clinical guidelines to participating providers. The Vendor should describe how it will meet this specification. |

## Administering Our QAPI Program [QU05]

Aetna's QAPI program aligns with the State's goals by monitoring and enhancing our quality of care and coordination of care and access to services, including physical health (PH), behavioral health (BH), dental care, and socially necessary services.

PROVEN RECORD OF EQR SUCCESS
**We have scored 100% on 7 of our last 8 EQRs.**
006.WV22

Aetna is committed to advancing evidence-based practices through our QAPI program, as required by 42 C.F.R. §438.330(a)(1), and NCQA accreditation standards as well as continuing to comply with section 7.2 of the Model Provider Services Agreement. Our local approach to implementing a comprehensive QAPI program centers around the aim of ensuring that local staff members are engaged in the process. **Our External Quality Review Organization (EQRO) and accreditation success has been based on the premise that staff in virtually all operational areas of the health plan are stakeholders in the QAPI process.** The local director of quality management facilitates a series of monthly QAPI workgroups and team meetings devoted to ensuring compliance with state, regulatory, and accreditation requirements. We have a total of nine teams (Quality, Member Experience, Population Health/Care Management, BH, Network Adequacy, Utilization Management, Pharmacy, Member and Provider Communications, and Member Services) that focus on specific elements of the QAPI process. Through at least monthly meetings, these teams monitor their individual team NCQA or EQRO requirements, track progress towards previously identified goals, and address barriers that may be identified. At our local Quality Management Oversight Committee meeting, our quality management director gives an update on all the teams progress, results, or any outstanding issues.

**Aetna Better Health of WV –
An innovative and dedicated partner**



Robert Wood Johnson Foundation and the National Academy for State Health Policy presented WV BMS a 2022 Medicaid Innovation Award, recognizing the State for demonstrating creativity, leadership, and progress in their Medicaid programs.

West Virginia Medicaid was recognized as the Care Coordination for Vulnerable Populations recipient for providing specialized managed care for youth in foster care by delivering continuity in health care through the most integrated and cost-effective way possible, while ensuring quality across services.

011.WV22

A key focus of our quality program is improving the member's biological, psychological, and social well-being with an emphasis on quality of care and the non-clinical aspects of all services. Where the member's condition is not amenable to improvement, our goal is to implement measures to assist the member to live safely in the least restrictive setting. Incorporating the continuous quality improvement concept (CQI), our comprehensive quality program is integrated across the entire continuum of care to deliver needed supports and services in the most integrated, appropriate, and cost-effective way possible to enhance coordination of care and access to services, including physical health and behavioral health, dental care, and SNS.

**The Quality Management program is a health plan-wide endeavor that uses an integrated and collaborative approach involving each functional area.** Integration of our quality management activities with other systems, processes, and programs throughout Aetna contributes to our quality scores exceeding our competitors. We maintain health information systems that collect, analyze, and report data to meet all contractual requirements. Our quality program includes a robust structure of oversight committees with members from across the health plan, as well as from the provider network representing the communities we serve.

### QAPI program purpose

The primary purpose of the QAPI program is to provide the structure and processes necessary to identify and improve clinical quality, maximize safe clinical practices, and enhance member, family, practitioner, and provider satisfaction across the various settings of care within the delivery system. Through our QAPI program, we ensure the services provided to children and youth in the foster care system, youth formerly in foster care up to age 26, eligible Children with Serious Emotional Disorders (CSED) in the CSED waiver program plus individuals receiving adoption assistance conform to the standards and requirements of regulatory and accrediting agencies, including the West Virginia Bureau for Medical Services (BMS) and NCQA.

### QAPI program goals and objectives

We base our strategic approach to improving health outcomes for members on CQI, the knowledge and experience of our local leadership, data analytics and system of capture, and a quality oversight structure guided by our board of directors. Our approach includes:

- Continuous performance improvement principles supported by our population health management strategy to improve health outcomes and reduce disparities
- Scientifically sound methods and continuous surveillance actions to improve the service delivery system and most importantly, members' health outcomes

**Our models enable us to develop targeted, measurable interventions, including rapid cycle improvement, to quickly evaluate the impact of an activity on our improvement goals and our key performance indicators.** Aetna strives to achieve the following primary goals to help improve health and social outcomes for our members and the impacts on families:

- Implement a QM program that effectively promotes and builds quality into the organizational structure and processes of the health plan
- Conduct continual monitoring and assessment of member care and services to ensure appropriate medical practice standards and the needs of our members and providers
- Identify & analyze opportunities for improvement with careful implementation of actions and follow-up

- Encourage member safety across the organization and network of providers
- Maintain compliance in local, state, and federal regulatory requirements and accreditation standards
- Develop and use health information systems
- Identify approaches to handling systematic problems and critical incidents

**Our quality management director is a West Virginia native and a registered nurse with extensive experience guiding quality management programs in the Mountain State and has been directly accountable for the local quality management program since 2014.** Our program adheres to all external quality review and accreditation requirements while meeting the needs of our most vulnerable children and youth population. Every Aetna functional area is accountable for quality outcomes—this focus across our organization has helped our quality performance exceed our competitors. For example, our community development director is a nurse by education, and previously worked in our quality department. He has incorporated a quality focus into our community development strategy. He understands the importance of regular reminders for preventive care such as well-child screenings. In his new role, he ensures that we include educational flyers in community food drive outreach boxes and back-to-school backpacks to help reinforce screening recommendations.

## Organization structure and administration

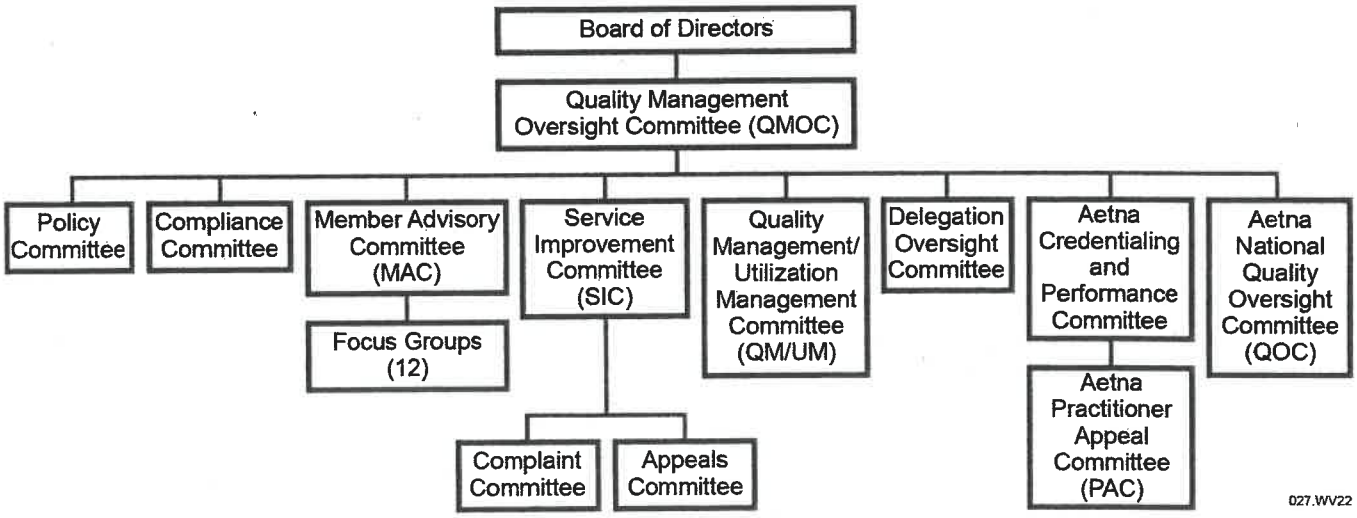



***Figure E.7-1: QAPI committee structure*** *- Aetna's comprehensive quality committee structure directs organization wide CQI initiatives.*

## Board of directors

Our QM department reports to the Board of Directors, the highest level of our organization, which has ultimate accountability for the West Virginia QAPI program and related processes, activities, and systems.

## Quality management oversight bodies and schedule of quality management activities

The local West Virginia QM department provides the administrative support for the coordination of committee meetings, meeting preparations, and follow-up activities. The Quality Management Oversight Committee provides executive oversight of quality activities and their integration across the plan through its receipt and review of reports and minutes from the committees. The table below provides a description of the Aetna local and national quality management committees.

| QAPI Committees | Description | Meeting Frequency |
|---|---|---|
| | **West Virginia-based Committees** | |
| **Quality Management Oversight Committee** | Chaired by the chief executive officer (CEO) with cross-functional representation; provides executive oversight of the QAPI program. | Six times a year |
| **Quality Management/Utilization Management (QM/UM) Committee** | Chaired by the chief medical officer/medical director with cross-functional representation and network providers; advises and makes recommendations on matters pertaining to the quality of care and service provided to members. | 10 times a year |
| **Delegation Oversight Committee** | Chaired by the director of quality management with cross-functional representation; advises and makes recommendations to QMOC about delegated relationships. | Quarterly |
| **Health Equity Leadership Partnership (HELP)** | Chaired by the Aetna Health Equity Lead with cross-functional leadership focused on Medicaid. Share and promote health equity best practices, review new strategies and technologies, and approve programs aimed at reducing inequities in the quality of health care received | Quarterly |
| **Complaint Committee** | Chaired by the complaint and appeals supervisor and reviews issues of expression of dissatisfaction by members, practitioners, or providers. | At least monthly |
| **Service Improvement Committee (SIC)** | Chaired by the chief operations officer with cross-functional representation; advises and makes recommendations to the QMOC and/or Aetna management about customer issues. | Monthly |
| **Appeals Committee** | Chaired by the complaint and appeals supervisor with cross-functional representation; reviews appeal trends and may render decisions on administrative or benefit-related appeals filed by members or providers. | Weekly |
| **Member Advisory Committee** | Chaired by the director of community development with cross-functional representation and member representatives; provides feedback to Aetna regarding strategies for improving member care and services, including health education and other member materials. | Quarterly |
| **Compliance Committee** | Chaired by the compliance officer with cross-functional representation; reviews, monitors, and assesses the effectiveness of the Aetna compliance plan. | Quarterly |
| **Policy Committee** | Chaired by the compliance officer with cross-functional representation; development, implementation, approval, and communication of all policies. | At least quarterly |
| | **Aetna National Committees** | |
| **Credentialing and Performance Committee (CPC)** | Composed of participating practitioners of various specialties who are all voting members, as facilitated by the Aetna regional medical director; responsible for credentialing and re-credentialing individual providers and conducting professional review activities. | At least every 45 days |
| **Aetna Practitioner Appeals Committee (Subcommittee to the CPC)** | Facilitated by an Aetna medical director; conducts professional review hearings of providers who appeal decisions made by the CPC involving professional competence or conduct of the provider. | As needed |
| **Aetna Quality Oversight Committee** | Chaired by the Aetna medical director or designee; conducts the credentialing/re-credentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors potential quality of care issues and complaints. | 10 times per year |

We integrate a governance model with responsibilities and accountabilities of top-level management and the board of directors. A formal committee structure allows for oversight of the QAPI program and for the flow of information to and from the board of directors. The committee members integrate Aetna medical functions, operations departments, network, and members into the QM program through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements. Aetna takes part in all quality meetings as requested by the West Virginia Department of Health and Human Resources (DHHR) to support the statewide quality goals, collaborate on initiatives, provide progress updates, and resolve barriers. We fully cooperate with the DHHR and EQRO requests for documentation.

### Quality management department

Under the direction of the chief medical officer/medical director, the quality management department administers Aetna's QAPI and provides administrative support for the health plan committees. The CMO/medical director reviews the reports and information and submits them to the appropriate committees and State agencies. **Our well-staffed quality management department includes an experienced team that is knowledgeable of the state's communities. This team** includes a director of quality management, Healthcare Effectiveness Data and Information Set (HEDIS) senior manager and coordinators, accreditation project managers, prevention and wellness outreach staff, and a quality practice liaison. The quality management staff maintains documents, medical records, and research documents in a safe, confidential, and protected manner. **Quality management department responsibilities include, but are not limited to, the following:**

- **Daily coordination and support of processes and monitoring activities** to promote enhanced coordination of care, access to services, and seamless care for members
- **Coordination with care management**, utilization management, and other departments to carry out quality and performance improvement activities
- **Partnerships with the Aetna Medicaid** organization's national quality management team in the review of information related to potential quality of care issues
- Performance improvement projects
- **Performance rates,** quality management and performance improvement activities monitoring
- **Regular reporting** of quality of care/service issues, trends, and issue resolutions
- **Annual review and revision of the QAPI program**; development and maintenance of the work plan
- Coordination of activities involved in the preparation of the annual QAPI evaluation
- **Coordination of member satisfaction surveys** including the annual consumer assessment of healthcare providers and systems (CAHPS) survey and the annual behavioral health member satisfaction survey to promote tailoring flexible programs to meet member needs
- EQRO

**The quality management department coordinates evaluation and follow-up on contacts from members and their caregivers/guardians, practitioners, providers, state or regulatory agencies, or other referral sources. It is the central area for receiving and responding to potential quality and/or risk management and compliance issues.** Quality management and performance improvement activities are part of a fundamental Aetna focus on meeting members' needs and modifying systemic issues to improve health and social outcomes for youth and impacts on families. The quality management department's role in initiating and coordinating communications about the

program is critical to linking members, family/caregivers, practitioners/providers, state and regulatory agencies, and other staff members and to keep information about quality management requirements and the status of activities current.

### Participation in multi-year Performance Improvement Projects (PIPs)

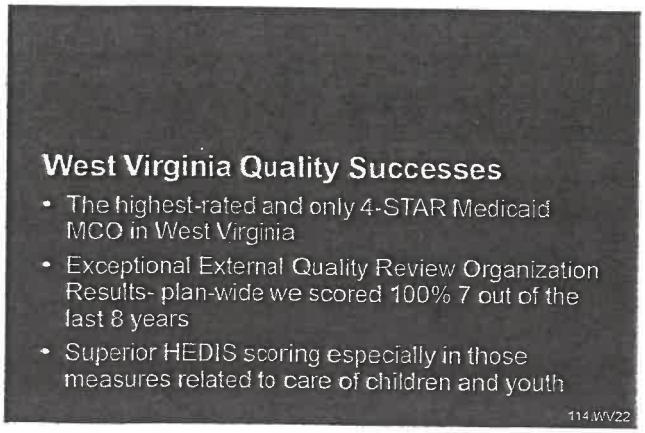
Our quality management includes PIP study measures in our QAPI program work plan and reports them to the Quality Management/Quality Improvement Committee regularly. Aetna uses PIPs to develop impactful programs, services and processes for our members that result in improved quality of care, member satisfaction and increased access to services. We base the selection of clinical and non-clinical PIP activities on the prevalence of conditions and risks among members and opportunities improvement. In designing our PIPs, we follow the guidelines outlined by the CMS publication EQR Protocol 7 Implementation of PIPs. We facilitate and support integrative clinical programs and data-driven initiatives based on evidence-based practices that address members' cultural and linguistic needs. We coordinate with the State and the other managed care organizations (MCOs) to ensure consistency and reduce provider burden to the benefit of all of Medicaid services.

Aetna uses reliable proven statistical methodologies in designing and evaluating performance improvement activities taking significant efforts to provide accurate and reliable data. Evaluation and analysis of the data source ensures it is appropriate to answer the study questions and is the most current available. We calculate and monitor the performance of selected PIP measures through multiple avenues, collaborating for customization in response to specifications provided by the NCQA, CMS, and the State, including the following:

- **Data repository**: Our NCQA certified vendor enables configuration of measures and seamless integration, aggregation, and analysis of claims, clinical, pharmacy, lab, and encounter data.
- **Data tracking/dashboarding**: Our quality team uses multiple dashboard tools and reporting platforms to support and evaluate PIPs, which allows us to proactively adapt our strategies to improve the health of our members.
- **Agile management**: If, through interim monitoring, we identify a need to adjust an intervention, we do so quickly and continue testing our improvement activities.

Using this approach, we successfully implemented the following PIPs that address care for adolescents; annual dental visits; follow up after emergency department (ED) visits for alcohol and other drug abuse or dependencies; and reducing out-of-state placements for children in foster care.

## Monitoring quality improvement strategies [QU10]




Aetna brings the full complement of our local and national quality improvement infrastructure to provide a comprehensive quality approach across the entire continuum of care services for West Virginia. **We are the highest scoring and only 4-STAR NCQA Medicaid organization in West Virginia. This includes Mountain Health Promise, Mountain Health Trust, and CHIP.** We achieve high-quality outcomes by developing meaningful member and provider programs tailored to specific communities including foster and youth populations to drive positive health outcomes in West Virginia. Our locally

based quality management staff model empowers us to make a significant impact in communities across the state to address social determinants of health (SDoH) for the most vulnerable West Virginia children and youth. Our strong connections with local providers and communities, through our Care Connection team care management model, enables our staff throughout the state to understand children and youth in the child welfare system and individuals receiving adoption assistance and the differences in the communities where they live. Aetna complies with Section 6.3 continuity and coordination of care of the Model Purchase of Service Provider Agreement as evidenced by the care coordination care description program description that was submitted to BMS by October 1, 2022.

Our quality management program design delivers person-centered, integrated care with the goal of improving access, health equity, and outcomes on both an individual and system-wide level. We use continuous improvement cycles to identify, select, and evaluate member and provider interventions. We use data to drive key decisions and evaluate effectiveness, adjusting to meet the needs of our members throughout the year. Annually, an evaluation team conducts a comprehensive review of the medical management programs, emphasizing demonstrated improvements in the quality of care and services provided to members as well as opportunities for improvement. **This annual Quality Management/Utilization Management (QM/UM) program evaluation includes:**

- **Assessment and evaluation of disparities across populations** via clinical process measures and outcomes, as well as access to equitable care
- Analysis and evaluation of quality and medical management program effectiveness including safe clinical practices
- **Analysis of year-over-year HEDIS trends** and comparison to benchmarks
- Member and practitioner experience with medical management program review including satisfaction scores and action plans
- Monitor requested services, timeliness and access, and coordination of care

One of our priorities is monitoring well-care metrics for children in the Mountain Health Promise program. These children often present with many barriers to accessing timely well care. The quality management staff work closely with the care management staff to identify these barriers and promote well-care visits in a multitude of ways. Our quality teams monitor data and performance metrics monthly and when we detect downward trends or anomalies in the data, our quality staff engages with care management to perform a root cause analysis and rapid cycle plan, do, study, act (PDSA) to identify actions to improve performance. Root cause analysis of missed appointments often reveals specific geographic areas within West Virginia where compliance with screening recommendations appear to be lower. We target practices in these areas and collaborate with specific provider partners and federally qualified health centers (FQHCs) to conduct well-visit clinics.

**West Virginia's Ted E. Bear Cub Club**

Ted E. Bear MD's Cub Club uniquely introduces age-appropriate health promotion strategies to our youngest members and their caregivers. Members who enroll in Cub Club participate in monthly challenges that highlight the importance of establishing health-focused behaviors early in life and receive a small reward each quarter for their participation. Engaging members year-round in activities such as our Healthy Smile or Fruits and Vegetables Challenges encourages caregiver and child learning and connection while contributing to improved health outcomes. 2023 challenges include Exploring Nature, Promoting Mental Well-being, and more!

170.WV22

**We also use the Ted E. Bear MD Cub Club to focus attention on the importance of childhood immunizations and proper dental care.** The table below demonstrates the significant Aetna

performance maintained in key well-care metrics in West Virginia despite the ongoing challenges posed by the COVID-19 pandemic.

| Measure | National Average | HEDIS MY2021 |
|---|---|---|
| **Annual Dental Visit—Total** | 47.39% | 62.7% |
| **Lead Screening in Children** | 62.23% | 64.48% |
| **Immunizations for Adolescents—Combo 1** | 77.73% | 80.54% |
| **Child and adolescent well-care visits (total)** | 49.55% | 58.38% |
| **Well-care visits in first 30 months of life (15 – 30 months)** | 66.04% | 81.01% |

**We have demonstrated our commitment to CQI, and examples of our successes include:**

- **Successful NCQA accreditation review** in September 2022 earning full accredited status until 2025
- **Focus on preventive care improvements** includes Mountain Health Promise program well-care visits for children 0-15 months of age increasing by nearly a 10-percentage points from measurement year 2020 (41.67%) to measurement year 2021 (51.13%)
- **Exceptional child CAHPS® member satisfaction scores** for Getting Needed Care and Getting Care Quickly with both scores exceeding the 90th percentile nationally in 2022
- **Metabolic monitoring for children** prescribed antipsychotic medications has been over 70% for the past two years, ranking in the 95th percentile nationally. This is a critical measure for many children in the Mountain Health Promise program.
- In addition to special analyses and programs and **ongoing assessment of HEDIS®** performance, The table below describes our strategy for continual surveillance to identify care gaps.

| Areas of Focus | Monitoring Strategies |
|---|---|
| **Statewide Availability** | • Evaluating the number and geographic distribution of primary care, BH, and specialty providers<br>• Continual monitoring of out-of-network utilization to identify contracting opportunities<br>• Ensure timely credentialing of providers and practitioners to reduce barriers to network participation |
| **Access to Care** | • Conducting annual population assessment analysis to promote equitable access to care and services and reduce disparities in health care outcomes<br>• Evaluating appointment accessibility for primary care, BH, and specialty care services<br>• Conducting annual continuity and coordination of care evaluations to ensure coordination between providers and across settings<br>• Monitoring of member experience metrics such as the CAHPS member satisfaction survey as well as member complaints and appeals to identify access-related issues |
| **Timeliness of Care** | • Providing regular EPSDT reminders to families of children and adolescents aged 0 to 21 years of age to encourage compliance with recommended health care appointments<br>• Providing regular reminders to practitioners with members in their care who may be due or past due for specific services |
| **Member Satisfaction** | • Monitoring member complaints or grievances during bi-weekly complaint committee meetings, ensuring timely resolution of all issues<br>• Conducting weekly member Appeals Committee meetings to address all member appeals<br>• Reporting Quarterly trends of member complaint and appeal activity to Service Improvement Committee<br>• Analyzing of member experience through the CAHPS survey annually<br>• Analyzing of member satisfaction with behavioral health services through the behavioral health member satisfaction survey annually<br>• Conducting periodic member satisfaction surveys of members enrolled in case management programs |

| Areas of Focus | Monitoring Strategies |
|---|---|
| **Coordination of Care** | • Conducting annual evaluation of coordination of care between medical care and behavioral health care<br>• Conducting annual evaluation of the continuity and coordination of medical care including member movement between practitioners and member movement across settings |
| **Demand for Services** | • Maintaining mechanisms for reviewing the entire range of care delivery systems, including all demographic groups, care settings, and services available to the member<br>• Using enrollment metrics to provide annual reports that include all demographic groups, care settings, and services available to the member<br>• Using utilization of service categories<br>• Identifying and evaluate quality and risk issues<br>• Implementing follow-up measures and action plans to resolve issues and prevent recurrences<br>• Monitoring actions for continued effectiveness<br>• Implementing rapid response process (i.e., Rapid Response team meetings)<br>• Evaluating open-ended responses from member satisfaction surveys such as behavioral health satisfaction survey |
| **Provider Workforce** | • Evaluating of the number and geographic distribution of primary care, BH, and specialty care providers<br>• Continual monitoring of out-of-network utilization to identify contracting opportunities<br>• Ensuring timely credentialing of providers and practitioners to reduce barriers to network participation<br>• Participating in monthly webinars hosted by the Network Team for new practitioners joining the network<br>• Tracking of practitioner completion of required educational trainings |
| **Quality of Care** | • Promoting optimum care and service and identify issues related to provider and member quality of care<br>• Monitoring outpatient and inpatient services to identify deviations from standard of care/service<br>• Performing ongoing off-cycle quality of care and quality of services reviews<br>• Managing quality and risk management referrals<br>• Evaluating overall case trends for the prior three years monthly<br>• Monitoring grievance and appeals for Potential Quality of Care (PQOC)<br>• Analyzing over- and under-utilization<br>• Monitoring member satisfaction |
| **Health Outcomes** | • Measuring effectiveness of the population health strategy and implement interventions to improve performance<br>• Identifying opportunities to improve health care outcomes for children and youth in the foster care system and individuals receiving adoption assistance<br>• Maintaining and/or improving HEDIS annual scores for targeted measures |

## Collecting and analyzing quality measures [QU12]

Aetna continues to comply with Section 7.4 of the Model Purchase of Service Provider Agreement. Our internal integrated IT/data quality measure engine is populated with timely vital data to make necessary decisions on how to intervene for the best quality outcomes. Our Quality Performance Management System incorporates clinical and administrative data including medical records, CAHPS results, claims, appeals, grievances, encounters, authorizations, quality of care incidents, pharmacy data, and SDoH from administrative and supplemental resources. We share this data with providers, and internal Aetna staff including care management and member services, to coordinate closing care gaps and improving quality. With this data, we assess the quality and appropriateness of care and support our community, provider partners, and members.

**Through the Quality Performance Management System and our health equity dashboard report, we can perform disparity reporting to analyze HEDIS measures by geography, race, ethnicity,**

**and gender to target our efforts and resources where they are most needed.** This approach enables us to make available a suite of reports to providers, members, and staff to improve quality, as well as State agencies as requested.

The table below includes a list of analyses and reports Aetna uses to monitor and evaluate the quality management and utilization management activities. The frequency column represents minimal review as we evaluate all these measures on an ongoing basis.

| Quality Improvement Measures | Description | Frequency |
|---|---|---|
| **Out-of-state placements** | Monitoring the percentage of foster care members who are residing in out-of-state placement. | Monthly |
| **Trending of HEDIS Measures** | Reviewing of administrative HEDIS rates to observe trends in performance | Monthly |
| **Analysis of member complaints and appeals** | Monitoring of the volume and types of member complaints and appeals including a drill-down by specific category to identify trends and monitoring of turnaround time. We track complaints by specific categories such as quality of care, access, attitude and service, billing/financial, and quality of the practitioner office site. | Quarterly |
| **CAHPS analysis** | Analyzing results of the adult and child member satisfaction surveys, including year-to-year comparison to identify trends in member satisfaction. Key CAHPS metrics include the rating of the personal doctor, the rating of the specialist seen most often, the rating of all health care, and the rating of the health plan. | Annually |
| **Behavioral Health (BH) member satisfaction survey analysis** | Analyzing the results of the behavioral health adult and child member satisfaction surveys, including year-over-year comparison to identify trends in member satisfaction. Behavioral health metrics include access to and timeliness of care, perceived outcomes, communication with clinicians, coordination of care, and the overall rating of behavioral health services. | Annually |
| **Overall assessment of member experience** | Completing a comprehensive analysis of multiple indicators of member experience, including member complaints and appeals and satisfaction survey data. This assessment combines the analysis of complaints and appeals, CAHPS, and the behavioral health member satisfaction survey. | Annually |
| **Clinical practice guideline/preventive service guideline review and update** | Reviewing current clinical practice guidelines and preventive health guidelines to ensure adherence to the latest recommendations from national sources. We base the reviews on source documents like American Diabetes Association, the American Academy of Pediatrics, the National Institute of Mental Health Anxiety Disorder, and the U.S. Preventative Services Task Force. | At least annually, more frequently if guidelines are updated by national sources |
| **Continuity and coordination of medical care** | Analyzing data on member movement between practitioners and across settings to evaluate continuity and coordination of medical care services. Metrics evaluated include surveys of primary care practitioners and specialists regarding satisfaction with information exchanged, post-discharge, assessment, and follow-up; HEDIS post-partum care and HEDIS diabetic eye exams. | Annually |
| **Continuity and coordination between medical care and behavioral healthcare** | Analyzing data about opportunities for improved collaboration between medical care practitioners and behavioral health care practitioners. Metrics include HEDIS anti-depression medication management, HEDIS follow-up for children who are prescribed ADHD medication, post-partum depression screening program, and outcomes for our neonatal abstinence syndrome program. | Annually |
| **HEDIS 2022 work plan** | Developing a work plan outlining initiatives targeting improvements in various clinical performance measures such as child and adolescent well care, annual dental care, diabetes care, and behavioral health services. | Annually |
| **Language services** | Analyzing member requests for translation services to ensure that member needs are met. The analysis includes a breakdown of all translation request received for the year. | Annually |

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| Measure Name | MY2021 Rate | MY 2020 Rate |
|---|---|---|
| **Immunizations for Adolescents - Combination 2** | 32.12% | 31.82% |
| **Lead Screening in Children** | 64.48% | 62.96% |
| **Well-Child Visits in the First 30 Months of Life (First 15 Months)** | 51.13% | 41.67% |
| **Well-Child Visits in the First 30 Months of Life (15-30 Months)** | 81.01% | 76.00% |

| Quality Improvement Measures | Description | Frequency |
|---|---|---|
| **Medical record documentation audit report** | Analyzing practitioner medical records to ensure compliance with recommendations for proper medical record documentation and confidentiality practices. Parameters assessed include documentation of member demographics, allergies, medication lists, treatment plans consistent with findings, and recommended follow up. | Annually |
| **Membership profile/population assessment** | Analyzing entire member population characteristics including age bands, racial/ethnic considerations, SDOH, geographical variations, high-volume diagnoses, and other characteristics of our membership. | Annually |
| **Network adequacy** | Comprehensively assessing of all measurements of accessibility and availability of care, including the number and geographic distribution of practitioners, appointment accessibility, and requests for and utilization of out-of-network services. | Annually |
| **Performance Improvement Projects** | Assessing clinical performance in various areas pertinent to the member population. PIP topics include care for adolescents, dental care, and reducing out-of-state placements. | Quarterly |
| **Potential quality of care** | Identifying, investigating, and tracking potential/actual quality of care concerns. PQOC cases are tracked by category, line of business, and outcome. | Quarterly |

We include the results of each of the above activities in the annual QAPI program evaluation provided to the State by June of each year. We provide raw data at the child level to the State upon request.

## Data-driven clinical initiatives in past 24 months [QU17]

### Clinical Initiatives targeting children and adolescents

Our priority is to improve member health outcomes in children in our Mountain Health Promise program through prevention and wellness activities. We base quality initiatives on our strategic plan, population assessments, gaps in care, and quality and medical management goals. Evaluation of child and adolescent well-care and immunization screening rates revealed an opportunity

for improvements in preventive care services for children and adolescents in the Mountain Health Promise program. The QM team analyzed the data by geographic region and identified specific areas with higher numbers of members who had not received recommended services and collaborated with network practitioners to encourage compliance.



Alex (not his real name) attends a well child event at Coalfield Health Center during Summer 2022 where he was one of 10 children seen by their PCP and health care teams for preventive screenings/shots.

**We implemented the following initiatives to promote the recommended screenings:**

- **$25 gift card** incentives for members ages 3 to 21 years for completion of the annual well-child visit

- **Targeted outreach** to parents/guardians of children in specific geographic locations to announce well-visit clinic days at their PCP's office and assist in scheduling an appointment (transportation is arranged as needed)
- **QM team members attend each well-visit clinic** to offer face-to-face assistance to the families and to present them with the $25 gift card earned for completing the well-visit
- **Texting campaigns** specifically targeting families with a child due for a well-visit examination to remind them of recommendations for care
- **Ongoing reminders** for well-visits from the care management team as they work closely with each Mountain Health Promise enrollee
- **Quarterly outreach** to practitioners with gaps-in-care lists showing members in their practice who are due for an examination
- **Aetna's Ted E. Bear, M.D. Cub Club** includes special offers to complete healthy activities to earn fun prizes. These healthy activities include well-visits, dental visits, immunizations, and general healthy behaviors such as getting adequate sleep and exercise. Recent Cub Club activities also placed an emphasis on nurturing mental well-being as well as physical well-being.
- **Financial incentives** for practitioners ($25) for each well-child visit completed for children 12 – 17 years of age in their practice
- **Outreach to providers** to encourage a well-child visit being completed at the time of a sports physical
- **Partnership with MedExpress** locations across the state to perform well-child visits (as appropriate) for children presenting for care at the MedExpress location



*Aetna's Ted. E. Bear, M.D.*

Analysis of the year-over-year data reveals that the interventions have been successful in improving key outcome measures for children and adolescents in the Mountain Health Promise program, as noted in the table below.

### Promoting Childhood Wellness in the Mountain Health Promise Program

Early results from 2022 also show continued improvement in screening rates:

- Lead Screening Rate increased 29.9% year-over-year for the first half of the year
- Childhood Immunization Status - Combo 2 Rate increased 800.5% year-over-year for the first half of the year

## Approach to periodically enhancing quality monitoring activities [QU23]

**Aetna conducts an annual evaluation of the QAPI program the first quarter of every year** to assess the overall effectiveness of our quality improvement program and CQI. This data-driven evaluation assesses completed and ongoing quality improvement activities, addresses past and current barriers, and informs the quality improvement strategy for the upcoming year. **In addition, we incorporate changes or enhancements to our quality management program throughout the year through several monitoring activities, including ongoing assessment of our HEDIS performance and our PIPs.** We monitor disparities to ensure optimal, equitable outcomes and appropriate member care. These evaluations include all aspects of the QAPI program to determine the extent and effectiveness of improvements in the quality of care and services.

Opportunities for improvement identified in the evaluation or articulated by DHHR or other key stakeholders drive the development of the goals and objectives. The QM department prepares the annual evaluation, identifies new or necessary changes and enhancements to our monitoring activities, and submits for review and approval to the QM/UM Committee, QMOC, and the board of directors. Another key element of our Quality Management program is direct feedback provided to us from network practitioners during our monthly QM/UM Committee meetings. This real-time feedback from network practitioners who care for members is critical to the implementation of the quality management program.

For example, during a first quarter 2022 QM/UM committee meeting where discussion centered on efforts to address SDoH needs within our population, we learned from network practitioners on the committee that many practitioners were often unaware of key SDoH resources such as the telephone number WV211. Aetna developed an SDoH reference tool for network primary care and BH practitioners and provided it to over 1,500 network sites in May 2022 and publicized it in the Mountain Health Promise member newsletter. By sharing this resource tool with both providers and members, it increases their access to community resources targeting SDoH needs and promoting quality of care.

**Highlight from West Virginia Managed Care Programs 2021 Annual Technical Report**

In Measurement Year 2020, Aetna Better Health:

- Received PIP submissions validation scores ranging from 98%–100%
- Submitted encounter data accurately 97% of the time
- Scored 100% in MCO Standards and Program Integrity Requirements Under the Contract

## Using Utilization Data to Monitor Quality Improvement [QU11]

Understanding utilization rates is foundational to improving member health outcomes, ensuring the closure of gaps in care, and decreasing health care costs. Aetna formally assesses utilization rates through our QM/UM Committee, including review of historic and current performance data for over-utilization of low-value care and under-utilization of high-value care. Over utilization of low-value care includes members using the ED rather than an urgent care center or their primary care provider, and examples of under-utilization of high-value care includes members missing their diabetic eye exams or post-hospital follow-up appointments. We produce monthly reports showing aggregate performance rates, predictive rates, and encounter data to identify enrollees needing care or outreach. Hotspot drilled-down reports show member characteristics, specific gaps by area, SDoH, and other variables to identify need for intervention based on region.

As directed by the chief medical officer/medical director, physical and behavioral health medical directors provide oversight of our clinical functions including QM, UM, and care management. The medical directors provide clinical leadership for the Quality Management/Utilization Management Committee, conduct medical necessity reviews, conduct peer-to-peer reviews, and provide mentoring and clinical leadership for the integrated care management program to improve utilization and quality outcomes.

**Aetna uses utilization data to identify specific patterns of higher utilization by county for children and youth to guide outreach. Once we identify specific geographic areas with higher ED utilization, we empower the Care Coordination team members in that county to quickly address unique needs that may be present in that geographical region.** Having our care coordination team members physically located in each region—with many of them onsite at local

facilities—greatly enhances our ability for rapid response to potential care and/or service issues with our children and youth.

An example of how we use utilization management data to track quality improvement trends over time is our monitoring of ED visits and readmissions related to our alternative payment model (APM) arrangements. Our medical director meets weekly with the APM partner medical director to review utilization trends and identify opportunities for improvement. The data shown below in the table below demonstrates successful achievement of utilization management data for value-based partner targets for ED metrics met. The targets were set based on the health plan and company goals or averages with a percentage improvement added. The purpose of the APM is for the provider to be engaged to assist in moving the utilization statistic in the right direction.

| Measure | 2021 Rate | Target | Target Met |
|---|---|---|---|
| **ED visits/1000** | 633.51 | 692.00 | Yes |
| **Readmissions-TANF** | 0.77 | 5.10 | Yes |
| **Readmissions-ACA** | 0.15 | 13.20 | Yes |
| **Readmission-SSI** | 1.66 | 16.0 | Yes |

## Addressing quality issues [QU16]

Aetna identifies, investigates, and monitors potential adverse events looking for trends and potential quality and safety issues. We define a potential quality of care concern as a concern raised to the health plan by anyone internal or external that requires investigation as to whether the competence or professional conduct of an individual network practitioner, facility, or ancillary provider adversely effects or could adversely affect the health or welfare of a member.

### Steps taken

Aetna integrated quality review process helps to ensure that issues involving quality of care or service, safety, complaints, or other areas of dissatisfaction are systematically evaluated. We require any employee who perceives a potential quality, risk management, or safety issue to refer the issue to the QM department for research and investigation. **A referral may originate in any of our departments that is communicated via an internal business application system.** Experienced Quality Management staff review and address the needs as indicated, including consult with medical directors to make recommendations.

In 2021, we received and investigated 177 PQOC cases. Types of cases investigated include a fall/trauma while being cared for in a health care setting, medication-related events, and other circumstances where the member alleges adverse effects on health or welfare. Case investigation may include contacting the practitioner and/or the facility involved in the case to obtain medical records and pertinent policies regarding the issue in question. The PQOC nurse refers the case to the appropriate medical director for case review, disposition, final action, and referral to the appropriate committees such as our Quality Oversight Committee or the Credentialing and Performance Committee. All cases were reviewed to identify any trends related to individual practitioners or facilities. There were 44 cases closed with no quality-of-care issues identified; 126 cases were closed as PQOC with further monitoring recommended; and 7 cases closed as quality-of-care issue identified. We did not identify any **trends with individual practitioners, and we identified and tracked one facility trend as per our quality management policy.**

### Responsible parties for addressing quality of care concerns

The CMO/medical director or designee oversees the peer review process that includes:

- Concurrent or retrospective evaluation of medical records
- **Referral of potential issues** to the National Quality Oversight Committee and/or Aetna Credentialing and Performance Committee for review and recommendation
- Analysis of identified issues for tracking and trending
- **Reporting of findings** to designated committees at least annually
- **Notification by Aetna to the appropriate regulatory board** or agency if a practitioner's contract is terminated, suspended, or limited due to quality-of-care issues
- Development and implementation of corrective action plans as necessary
- Provision of Fair Hearing rights to practitioners

Aetna outlines written policies and procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or services that should have been furnished were not, including:

- Specification of the types of problems requiring remedial/corrective action
- **Specification of the person(s) or body** responsible for making the final determinations regarding quality problems
- Specific actions to be taken
- **Provision of feedback** to appropriate health professionals, providers, and staff
- **The schedule and accountability** for implementing corrective actions
- The approach to modify the corrective action if improvements do not occur
- **Procedures for terminating** the affiliation with the physician or other health professional or provider

**Actions taken by the committee include peer-to-peer discussion, practitioner corrective action plan, financial penalties, suspension of privileges, termination of contract, and additional follow-up determined necessary by peer review.** Potential quality of care concern data is aggregated monthly and reported to the Quality Management/Utilization Management Committee and Quality Management Oversight Committee. If the termination results in a material change in the network, we provide written notice to the DHHR and other applicable regulatory bodies or agencies.

We incorporate information resulting from potential quality of care concern activities into the QAPI and we use this information in re-credentialing, re-contracting, and evaluation of provider performance. We coordinate our QAPI activities with other performance monitoring activities, including utilization management, risk management, and resolution, and monitoring of members complaints and grievances. Aetna links QAPI activities to other management functions, such as network changes, benefits redesign, medical management systems, practice feedback to providers, and member education and treatment services.

### Peer review process

Our policies and procedures describe the peer review/appeal process and the actions we may take if we identify a quality issue. Such actions may include, but are not limited to, development of a corrective action plan with a description of the timeframe for improvement; evidence of education, counseling, and development of policies and procedures; monitoring and trending of data; limitation or discontinuation of the practitioner/provider's contract with the plan. The peer review process focuses on the issue identified, but, if necessary, could extend to a review of utilization, medical necessity, cost, and/or health practitioner credentials as well as other quality issues.

The QM department coordinates peer review activities although they may require the participation of Medical Management, Provider Services, or other departments. We may request external consultants with special expertise (e.g., oral surgery, cardiology, oncology) to participate in peer review activities, if applicable. Applicable state and federal laws govern the peer review process and contain immunity and confidentiality provisions that protect the peer review process.

### Fair hearing appeal process

The right of appeal is available to practitioners/providers whose participation in our network was limited or terminated for a reason based on the quality of the care or services provided. Our policy describes appealable actions that include the restriction, reduction, suspension, or termination of a contract under specific circumstances. The appeal process adheres to federal and state laws and regulations and Aetna-approved policies including the requirement for the health plan to report actions that result in suspension or termination of a practitioner/provider's contract. The Aetna Practitioner Appeal Committee conducts the appeal process. Practitioners receive reports of final decisions upon completion of due process actions. The committee tracks and trends all decisions.

### Member complaints and appeals

The member complaint and appeals process includes the review of member concerns and their resolution in a satisfactory and timely manner. The appeals process addresses denied claims or other services relative to a member's benefits. The process provides a member the opportunity to attend a meeting before our local Aetna Appeals Committee for review and final determination. The complaint and grievance supervisor in collaboration with the Member Services and Provider Services departments informs and educates members and practitioners about a member's right to file a complaint or appeal or request a Fair Hearing and assists members in filing a complaint or appeal or to request a Fair Hearing.

The Provider Services department gives each practitioner information about the member complaint, appeal, and Fair Hearing process at the time they enter a contract with Aetna as well as through a variety of other sources, including the provider manual and on the Aetna website.

Members receive information about the complaint, appeal, and Fair Hearing process in the member handbook and in notice of action letters issued in conjunction with the utilization review process. The complaint and grievance supervisor works collaboratively with the chief medical officer/medical director or designated physician and the quality management, medical management, member services, and provider relations departments to facilitate the resolution of all complaints and appeals.

### Timeframes for resolution

Aetna ensures that we address member satisfaction in a timely manner and in accordance with the Model Purchase of Service Provider Agreement. Members have 60 calendar days from the date of the notice of action to file an appeal, and Aetna will respond to the appeal within 30 calendar days from the day the appeal is received. For complaints and grievances, members will receive a response within 90 calendar days from the date the complaint is received. Standard resolution and notice of appeals occur following the timeframes established by the DHHR and will be extended up to 14 calendar days if the member requests or if it is shown that additional information is necessary and that the delay is in the interest of the member. For Fair Hearings members must request the hearing no later than 120 calendar days from the date of the decision. The State will hear the member's case and decide within 90 calendar days of the request for a State Fair Hearing.

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## Taking action against physical health and behavioral health providers demonstrating unacceptable performance [QU03]

Our comprehensive PCP model places primary care providers at the forefront of managing members' care. Our goal is to ensure physical health and behavioral health providers have our dedicated support in resolving administrative burdens experienced with managing a provider practice so that practitioners more time for members as well as mitigating practitioner underperformance. To support this goal, we are introducing a multi-faceted system through a locally based Provider Optimization Delivery (POD) that partners with providers. It is a flexible model that varies in intensity based on need, data insights that increase quality, and provider payment strategies that improve population health. **Specific staff who support our POD model include:**

- **Regionalized provider** liaison/engagement representative (a provider point-of-contact)
- **Provider relations representative** (support and triage questions to the correct owners)
- **Quality support advisor(s)** (cost and utilization support)
- **Claims representative** (root cause analysis/reprocessing/feedback)
- **Network operations** (Credentialing) representative (data support)
- **Value based service (VBS)** provider engagement manager (VBS and readiness support)

**Our POD teams work directly with our primary care provider groups to track, monitor, and analyze HEDIS and utilization management data and trends. We leverage utilization, care management, and quality data to support interventions and offer value-based provider incentives around HEDIS to measure performance.** Our POD staff conduct scheduled meetings with our network Primary Care Providers to review data specific to the group and develop strategies and suggestions to help providers close care gaps and improve their quality scores. These actions assist in improving member experience, member outcomes, and operational efficiency.

Our quality management and provider services staff also work together to monitor network practitioner and provider performance, including SNS providers. Quality management staff assists provider services staff in developing measurable objectives to evaluate provider performance, analyzing data collected in the monitoring process; and preparing information for the QMOC. If the reported data indicate the need for an action plan or additional studies, QM assists in developing tools and reporting results and outcomes to the QMOC and to the DHHR, as appropriate. Our Quality Oversight Committee conducts peer review and investigates quality of care or service, and member safety issues, makes recommendations to the CMO/medical director, and requests follow-up by the Credentialing and Performance Committee (CPC), if appropriate. The CPC conducts professional review activities involving the practitioners whose professional competence or conduct adversely affects or could adversely affect the health or welfare of members. The range of actions available to the Quality Oversight Committee and/or the CPC includes practitioner education, requirement of a corrective action plan, or termination of the practitioner contract, if indicated. We report actions taken by the Quality Oversight Committee or the CPC to the QMOC and the DHHR, as appropriate.

**Our local West Virginia quality management team actively works with network practitioners across the state when we identify unacceptable performance patterns, such as gaps in care or issues with medical record documentation practices.** For example, during the annual medical record documentation audit, we compare individual practitioner performance to the established goals. Any practitioners who score below the goal receive individualized feedback on areas not meeting the goal. The quality management team shares these results with the provider services team, who meet

directly with the provider to review the results and offer suggestions for improvement. We automatically include those practitioners who do not adequately meet the medical record documentation goals in the next year's audit to review a sample of medical records again and assess for improvement. If the provider continues to underperform, the range of actions could include continued education, corrective action plan, or committee review for possible termination.

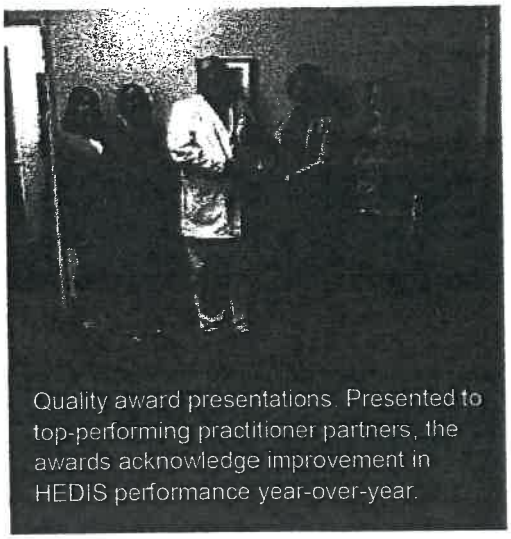
**Kepro authorizes SNS authorizations according to the SNS utilization management guidelines.** After the prior authorization of the service, the SNS provider conducts the service with the member. On an 18-month cycle, Kepro conducts consultative reviews of all enrolled providers who have been active during the specified review period. Retrospective quality reviews may be onsite or office-based (desk reviews). Kepro selects a sample of service records of members receiving SNS using a sampling methodology based on volume and complexity of service array. They also evaluate the provider's credentialing information for the retrospective review. Kepro completes a written report which includes a discussion of the results along with recommendations within 30 calendar days and provides it via mail or electronically to the provider, our health plan, and the Bureau for Social Services (BSS).

Kepro contacts the provider within 10 business days to inquire if the provider has questions regarding the report, to discuss corrective actions, and to offer/provide technical assistance or schedule training, if necessary. Follow-up reviews may be warranted based on the scores from the past review period being under 80%. Providers must score at least 80% during their retrospective review for each service reviewed. Kepro places providers failing to meet 80% on a probation period of six months for each respective service failing to meet that threshold by BSS. The provider must arrange and complete training and/or technical assistance from Kepro during this period. At the end of the probation period, Kepro conducts another retrospective review of the services with scores below 80%. If the provider continues to score less than 80% for that service, Kepro recommends to BSS that the service be closed for that provider and the provider should no longer be eligible for referrals for that service. If the provider scores a zero on any safety related service during any review, the service is automatically closed for the provider. Permitting service agencies to re-enroll for a closed service in the future is subject to BSS policy and review decision.

## Rewarding physical and behavioral health providers [QU02]

Through our APM arrangements, we incentivize and reward both physical and behavioral health providers. Our goal is to enhance quality of care through arrangements, such as pay for performance and shared savings. We maintain a robust quality program by monitoring provider performance to support a network that demonstrates understanding, accountability, and ability to address health needs of members while supplying accessible, high-quality care and services, and supporting value-based payment programs to drive high-value care.

We actively work with network providers to understand their needs to be successful in achieving rewards and incentives; we listen and develop processes and tools to support them, including reducing administrative burden and altering our reporting formats to make them more actionable. Additionally, we hold quarterly Joint Operating Committee (JOC) meetings with our APM partners. One objective of these meetings is to share information to help these partners meet their quality performance goals. Information provided includes HEDIS year-over-year data compared to benchmarks and upcoming opportunities for collaborative well-visit clinics. Our Quality All Star Program highlights overall performance of those providers who achieve high-quality HEDIS scores. Aetna complies with Section 3.7 of the Model Purchase of Service Provider Agreement.



Quality award presentations. Presented to top-performing practitioner partners, the awards acknowledge improvement in HEDIS performance year-over-year.

## Clinical guidelines for participating providers [QU15]

We use national policies and processes for adopting and updating clinical practice guidelines and preventive health guidelines from nationally recognized sources and in compliance with 42 CFR 438.236 practice guidelines and NCQA standards. Our quality management director brings all guidelines to our Quality Management/Utilization Management Committee for review, input, and adoption. We make modifications to the guidelines by consensus with each clinical practice guideline being formally approved by our Quality Management Oversight Committee, with guidelines updated at least every two years. We use evidence-based clinical practice and preventive health guidelines from nationally recognized sources, as our standard of care.

A physician-based committee reviews the guidelines that are then presented to our local Quality Management/Utilization Manage Committee and our Quality Management Oversight Committee for review and approval. See the table below for examples of current clinical practice guidelines adopted in September 2022.

| Clinical Practice Guideline | Description |
|---|---|
| **Alcohol use disorder** | American Society of Addiction Medicine Alcohol Withdrawal Management – January 2020 |
| **Asthma** | National Heart, Lung and Blood Institute- 2020 Focused Updates to the Asthma Management Guidelines |
| **Attention-deficit/ hyperactivity disorder (ADHD)** | American Academy of Pediatrics: Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents, October 2019 |
| **Diabetes** | American Diabetes Association Standards of Medical Care in Diabetes, 2022 |
| **Major depressive disorder** | American Psychiatric Association – Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts, February 2019 |
| **Substance Use Disorder** | American Society of Addiction Medicine Consensus Statement – Appropriate Use of Drug Testing in Clinical Addiction Medicine, December 2019 |
| **Eating Disorders** | Identification and Management of Eating Disorders in Children and Adolescents, January 2021 |
| **Tobacco cessation** | Centers for Disease Control and Prevention Cessation Materials for State Tobacco Control Programs: multiple guidelines |

We support widespread dissemination of clinical practice guidelines to our providers through the website, web portal, provider manual, onsite visits, trainings, and fax blasts. In addition, members and

their caregivers or guardians can contact the member services department at any time to request a hard copy of the clinical practice guidelines. We help ensure providers receive up-to-date information on clinical practice guidelines and send out email blasts notifying them of any changes made. Provider relations staff also inform their assigned providers of changes that occur to the clinical practice guidelines. Staff provide explanation to members in a culturally and linguistically appropriate manner.

In addition, we share clinical practice guidelines and preventive health guidelines with our physical and behavioral health practitioners during the provider workshops held throughout the state, at quarterly provider webinars for all new practitioners joining the network, and on our provider website. We share best practices quarterly with our regulator at the time of our PIP updates and annually during the EQR.

## Provider accountability

| | |
|---|---|
| QU19 | The Vendor should profile the quality of care delivered by network providers, including, but not limited to:<br>• Primary care providers<br>• High-volume specialists<br>• Hospitals<br>• Residential mental health treatment facilities (RMHTF)<br>• Children with Serious Emotional Disorder (CSED) waiver providers<br>• Other acute care providers<br>1) The Vendor should describe its practice of profiling the quality of care delivered by network providers; 2) The Vendor should provide the methodology for determining which and how many providers will be profiled. |
| QU01 | The Vendor should develop Physician Incentive Plans to reward physical, oral, and behavioral health providers that adhere to the quality or performance standards of the Agency. These plans must be disclosed to the Agency and follow federal regulations including, but not limited to, 42 CFR 438.6, 42 CFR 422.208, and 42 CFR 422.210. The Vendor should describe how it will meet this specification, as well as any other ways it would actively work with network providers to ensure accountability and improvement in the quality of care provided. |
| QU08 | The Vendor should use alternative payment structures for providers the Vendor has direct contract oversight—including, but not limited to:<br>• Provider incentives and/or overcoming limitations of diagnosis-driven eligibility—for the percentage of provider contracts identified in the SPA to increase healthcare quality and<br>• Efficiency through collaboration and innovation to improve access to comprehensive health care.<br>• The Vendor should report annually to the Agency on its activities related to alternative payment structures for those providers which the Vendor has direct contract oversight, according to the SPA. The Vendor should describe: 1) A plan for alternative payment structures; 2) Mechanics by which incentive payments to providers to improve quality of care would be made; 3) Quality metrics that would be required for provider incentives and shared savings. |
| QU09 | For those providers the Vendor has direct contract oversight, the Vendor should identify and incorporate into alternative payment structures opportunities including, but not limited to:<br>• Cost savings and<br>• Reductions in inappropriate utilization of services, including, but not limited to, inappropriate admissions and readmissions<br>The Vendor should report annually to the Agency on its activities related to alternative payment structures for those providers over which the Vendor has direct contract oversight, according to Appendix 3: Service Provider Agreement (SPA).<br>The Vendor should describe: 1) A plan for alternative payment structures; 2) Quality metrics that would be required for provider incentives and shared savings; 3) Mechanics by which incentive payments to providers reduce cost, reduce inappropriate utilization of services, and/or inappropriate admissions/readmissions |

## Approach to provider profiling for quality of care delivered [QU19]

Our comprehensive POD model is being implemented to ensure providers have our dedicated support in resolving administrative burdens experienced with managing a provider practice. Our model allows dedicated Aetna staff to be aligned within a POD structure to meet all the provider's needs. Our POD model works directly with our provider groups and network facilities to track, monitor, and analyze

utilization data and trends. We leverage utilization and quality data to support interventions and offer value-based provider incentives around HEDIS to measure performance and reduction in ED utilization. Our POD staff conduct scheduled meetings with our network providers to review data specific to the group, including gaps in care that might lead to inappropriate use of the ED. After reviewing ED access patterns, we work with our providers to develop strategies and suggestions, such as offering expanded or different office hours. **To further support the POD model, we have added a new key position to the quality management team. The West Virginia based quality practice liaison will be the quality representative who facilitates quality related education, training, and best practice sharing on HEDIS and CAHPS in the POD delivery model.** We will also use our Provider Advisory Council meetings and Joint Operating Committees as a forum for our network providers to discuss quality and access issues.

Our POD system will run comprehensive provider profiling reporting that is unique to our network providers. We use the provider profiling report to educate primary care providers, hospitals, high-volume specialists, and other acute care providers about their practice patterns and their overall performance relative to their peers. We use key quality and efficiency indicators and use these reports to collaborate with providers in identifying opportunities to improve member experience. A key benefit is that reporting may be broken out by individual provider. The providers can trend their data, track gap in care activity, and capture actionable data for improving outcomes. We provide monthly gap-in-care reports to providers that show the gaps in the care provided to members (i.e., members with multiple ED visits without follow-up or members with late well-child visits) and the recommended best practices in health care based on HEDIS requirements.

**We will use the indices dashboard from Inovalon (our HEDIS software vendor) to share key information with providers.** All our quality teams have been trained to use indices reports which enable providers and our quality team staff to identify gaps early and implement interventions to close the care gaps. The dashboards are populated with up-to-date Aetna Medicaid data and reflect gap closures directly from QSI-XL. The suite was launched in August 2022 and will be live in West Virginia the second half of 2023. Key functions will include:

- **Gap in care performance for all measures**. Both NCQA and state-specific measures are available at the plan level and at the reported population levels. We can compare and see provider performance for their attributed membership by measure against Health Plan Rating benchmarks.
- **Drill-down views**. All these views allow drill down to the member level to enable directed outreach at the market level and facilitate communication with providers to provide quality of care to our members.

With the roll-up of the data from provider reports and HEDIS activity, Aetna proposes delivering semiannual updates to the DHHR on APM activity and outcomes to allow for claims data to process and provide accurate updates on the metrics. Aetna complies with the format prescribed by the DHHR to include status, progress, successes, and challenges. We work with the DHHR to use the findings to identify additional opportunities for improvement.

Aetna will use various data points to develop practitioner profiles to monitor practitioner practice patterns along with members' health outcomes to identify opportunities for improvement. **The objectives and goals of practitioner profiles include:**

- **Identifying practitioner utilization patterns** that vary significantly from peer network practitioner groups
- Identifying medical management and utilization trends and address through practitioner outreach

- Providing information to network practitioners about their practice patterns
- Providing information for use as a component of QM oversight
- Providing information for use as a component of practitioner incentive compensation
- **Sharing objective, reliable, and meaningful data** to providers to foster closer working relationships

**Aetna will use the provider profile reports generated by the Aetna Medicaid organization's APM Informatics team. Our APM regional manager will share the results quarterly with the QM, Medical Management, and Operations teams at the health plan. Then, we will share it with providers.** We will provide a full explanation to providers, and our preference will be to sit down and meet with the provider to discuss results and collaborate with them to identify areas of improvement. Aetna will provide support for providers to help support their patients and our members.

Our chief medical officer or designated medical director will access the profile interface quarterly to review identified practitioners' utilization patterns, trends, and costs during the previous year. We will share these reports with the provider, and if a profile reflects practices that do not further our health care mission, e.g., low performance of HEDIS measures, our chief medical officer /medical director will request that the practitioner develop a corrective action plan.

The provider profile report will also monitor member satisfaction using data from complaints and appeals as well as administrative quality through compliance with access requirements. We will format provider profiles to allow comparative feedback for individual practitioners compared to established targets, state or national benchmarks, their practices or groups, organizations, geographically relative peers, or the overall performance of the provider network. For groups and organizations, the profile will provide a summary of all affiliated practitioners' performances. We will furnish all reports in HIPAA-compliant electronic and hardcopy formats depending on provider requests.

**Each provider profile report will contain the following, at a minimum:**

- **Coding tool**: Defines the performance metrics and provides detailed information on service coding used on claims to obtain credit for metric-related service provisions
- **Performance profile**: We have both an electronic online report and print text report for each practitioner or provider group listing the metrics, member denominator, and numerator counts, current period performance for each metric, target(s) for the metric, and the provider's progress in achieving an award for performance for each target
- **Member intervention list**: A list of attributable members for each metric such as well visits, immunizations, and other screenings, with demographic information identifying members still in need of care or services; this intervention list facilitates outreach and registry used to promote member compliance and garner better performance outcomes for both the provider and members

### Methodology for Determining Providers to Be Profiled

To address clinical quality through the POD, we will create profile reports for primary care providers with 100 or more unique child/youth members (but may adjust numbers depending on a provider's membership mix), as well as acute care providers, hospitals, targeted behavioral health providers, and our high-volume specialists. We will leverage the existing experience and best practice profiling process within our commercial and Medicare lines of business to develop effective reporting in West Virginia for implementation with a flexible approach to adapt the content and frequency. Additionally, the exchange of information with CSED providers would include a review of claims and service utilization to

ensure appropriate authorization of services. We will also monitor key metrics in our residential treatment facilities such as length of stay, quality discharge planning, and follow through with after care and work directly with those facilities if there is an outlier. CSED waiver provider profiling will include important metrics such as timely submission of documents for the plan of care, transfer forms, and incident management reporting.

### Profiling PCPs and Other Acute Care Providers

For the purposes of profiling, we have defined other acute providers to include health departments and free clinics, but we will adapt them based on further clarifications as provided by the State. Our primary care provider and other acute care provider profile report may include, but is not limited to, the following measures:

- Lead screening for children
- Follow-up care for kids prescribed ADHD medications
- Well-child visits at 15 and 30 months
- Children/adolescent access to primary care services
- Antidepressant medication management: effective acute phase treatment and effective continuation phase treatment (HEDIS)
- Diabetes control: HbA1c <8 percent (HEDIS) or absence of an HbA1c screen
- Cervical cancer screening (HEDIS)
- Appropriate medications for members with asthma (HEDIS)
- Potentially preventable emergency room visits; potentially preventable admissions
- Emergency room utilization and hospital readmissions

### Profiling high volume specialists

We identify specialists serving a high volume of children and youth as determined by claims spend in the foster care system and individuals receiving adoption assistance through claim volume data. We also look at those high-volume specialists with at least 10 full episodes of care. The analysis includes re-admission rate, ED visit rate, and an analysis of selected appropriate HEDIS measures for the target population. For example, if profiling a high-volume endocrinologist, we would look at their population of individuals living with diabetes and review their HgA1c, ED visits, and inpatient rate. We would blindly compare high-volume specialists against their peers to demonstrate how they perform compared to their peers.

### Profiling hospitals

We use metrics, such as 7- and 30-day post-discharge primary care provider visit follow-up, potentially preventable hospital admissions, and low-acuity emergency room visits to profile our network hospitals that are seeing a high volume of children and youth in the foster care system and individuals receiving adoption assistance. As with our high-volume specialists, we will report on these metrics and provide the hospitals with a report profiling their performance as compared to their peers. Aetna believes that this process encourages the facilities to put operating procedures in place to help ensure discharging patients have a primary care provider office visit scheduled to assess and monitor medication, help ensure adequate supports are in place post-discharge, and make sure the medical home is intact. We recognize the need to support this collaboration between the discharge staff along with the primary care provider, especially for members in rural areas. We believe that this process adds support to members

in rural settings and gives accountability to us and the hospital to make certain a high quality of care is provided to our shared members.

### Review of profile data

As part of our QAPI program, we are deploying new tools that will have the capacity to generate provider profile indicators (which will go live the second half of 2023) that are developed based on their relevance to the applicable population(s), establish benchmarks, assess the results of provider profiles, monitor provider progress on corrective action plans, and develop quality improvement initiatives as needed. We notify all providers on the selected indicators and methodologies used to generate performance scores at the beginning of each reporting period.

### Sample quality profile reports

Network primary care and acute care providers providing services to members will receive performance reports. Unlike similar tools in the market, the provider profile report will contain a member list of needed care or services for each indicator, so providers can address all known gaps in care when members are in the office or for use in provider/member outreach. We will continue to refine the tool, especially requesting regular feedback from providers to make it more user-friendly, and we offer interactive formats for easier accessibility on computers and mobile devices.

To develop provider scorecards, we will leverage data analysis and performance metrics to direct activities for CQI addressing health inequities and preventive care. Data capture and analysis for the scorecards will include examples such as HEDIS performance profiles; EPSDT utilization; network adequacy reporting including out of network usage; pharmacy and medical utilization reports; prevalent condition heat mapping and SDoH needs identified at the community level; and claims. We will use monthly gaps in care reports from the integrated quality management data systems to perform member outreach.

### Rationale for selecting performance measures in sample report

We select specific measures in the profile report because they relate to a high volume of the eligible population of children and youth in the foster care system and individuals receiving adoption assistance, as well as measures that are important to the State. These measures are consistent with our goal of promoting preventive care and align with the DHHR's goals. The team will also pull measures from Mountain Health Promises PIPs, gap in care reports, and other key West Virginia projects.

### Proposed frequency of report distribution

Our POD teams will generate the profile reports quarterly with our provider services representatives, meeting with these providers in their offices biannually to share the profile reports and answer questions and mitigate issues or problems; educate them on Medicaid managed care, billing, prior authorization requirements, and specific issues facing their members. The profile reports verify demographic and roster information, appointment availability, and compliance with Americans with Disabilities Act and our cultural competency requirements and complies with Section 3.7.7 of the Model Purchase of Service Provider Agreement concerning timely payment requirements. Representatives will provide education on any topic pertinent to the provider and help them to understand their performance in relation to the defined measures and their standing among their peers. **Our provider profiling will expand beyond traditional physician-based providers and includes facilities and home and community supports and services.** We will create ad hoc profiles as needed throughout the year based on performance indicators. All providers who meet eligibility requirements for program

participation will receive profile reports, which we distribute by mail, fax, and in real-time through the provider web portal.

## Rewarding physical, oral, and behavioral health providers [QU01, QU08, QU09]

Through our advanced APM arrangements (which are refreshed annually), we currently incentivize and reward physical and behavioral health providers and are also evaluating how to best incent oral health providers. This supports all partner providers, encourages efficient use of resources, and a flexible mechanism to deliver needed supports and services to members.

**OUR VALUE-BASED SERVICES CONTRACTS**
CONTRACTS BY-THE-NUMBERS
- Charleston Area Medical Center – 19,354
- Marshall Health – 6,996
- West Virginia University – 13,957

105.WV22

Once we complete our evaluation, we are confident that we can quickly implement the oral component. Our goal is to enhance quality of care through arrangements, such as pay for performance and shared savings. We maintain a robust quality program by monitoring provider performance to support a network that demonstrates understanding, accountability, and ability to address health needs of members while supplying accessible, high-quality care and services, and supporting value-based payment programs to drive high-value care. **We actively work with network providers to understand their needs to be successful in achieving rewards and incentives; we listen and develop processes and tools to support them, including reducing administrative burden and altering our reporting formats to make them more actionable.** Our Quality All Star program highlights performance of those providers who achieve high-quality HEDIS scores in key measures such as childhood immunizations, well childcare, and diabetes care. As we continue to celebrate our top-performing providers, we focus on leveraging their performance outcomes by sharing best practices during webinar trainings and other forums.

### Overcoming limitations of diagnosis driven eligibility

Aetna wants all members to be eligible to participate in our provider APM arrangement; therefore, we do not use diagnosis-driven eligibility. We develop APM arrangements that serve populations as well as those with specific diagnoses and have both general and specific reporting to support these APM arrangements. We currently have APM agreements with the Charleston Area Medical Center and Marshall Health to cover the wide range population in key areas of the state, as well as some agreements for specialized providers. **Our 2023 agreement with Marshall Health specifically includes the foster care population (as well as an expansion of counties)**, and we will consistently review and work with this provider to ensure appropriate support to practitioners and members. .

### Using APM agreements to enhance cost savings and reducing inappropriate admissions

**We have been working with providers on provider-based contracts since 2004, which included a shared risk contract with a large, in-state provider that included quality and efficiency targets.** We also include cost and utilization metrics in certain arrangements such as shared savings where there is risk.

We understand the importance of clearly defining metrics for providers, specifying what is included and not included in our agreements. Our medical loss ratio serves as a total cost of care metric. Additionally, we have measures depending on provider specialty type, as well as traditional and significant transitional provider types. We promote value-based arrangements with key partner providers to improve quality scores and health outcomes. Each value-based arrangement can be best customized to suit the needs of the provider, members, and the health conditions of the region. Aetna complies with

provider reimbursement requirements as outlined in Section 6.1 of the Model Purchase of Service Provider Agreement

We believe that all APM arrangements are put in place with the overall goal of reducing costs while increasing quality of care delivered to our members. **Examples of our APM arrangements in West Virginia include pay for quality (2C), PCMH (2A), shared savings (3A), and population-based payments (4B). Aetna plans to use the APM arrangements described in the table below.** These models were selected based on the current and future predicted capabilities of providers in West Virginia. Our goal is not to move providers too quickly, but rather to work with them, give them support, and help them gain confidence to move to the next level of model for success. We are researching innovative ideas for providers to submit CPTII codes for controlling blood pressure, comprehensive diabetes, and prenatal and postpartum are slated for inclusion as we continue to evolve our APM arrangements. We are also reviewing methods to increase Z-code billing. These models were selected based on the current and future predicted capabilities of providers in West Virginia. Our goal is not to move providers too quickly, but rather to work with them, give them support, and help them gain confidence to move to the next level of model for success. **[QU09]**

| Type of Arrangement | Rationale for Selecting Model | HCP-LAN APM Framework maturity level |
|---|---|---|
| **PCMH arrangements** | Allows practices to get infrastructure funding to support transformation (such as health information technology and care delivery support) within their practices. NCQA certification is not required. | 2A |
| **Incentives for reporting Z-codes** | Allows providers to progress towards payment for reporting while providing valuable information regarding a member's SDoH status. | 2B |
| **PCMH with quality incentives** | Allows rewarding for performance on specific quality measure targets as well as infrastructure payments to support transformation. | 2C |
| **Training in adoption competency** | Allows providers to demonstrate competency by undergoing training. | 2B |
| **Shared savings arrangements** | This all-upside arrangement allows practices to become familiar with the connection between cost and quality performance and allows for sharing of cost-savings after quality targets are met. | 3A |
| **Bundled payments** | This is an up- and downside arrangement related to bundled payments for services and allows specialists to participate in value-based programming. | 3B |
| **Primary care PCMH with shared savings and losses (losses are capped initially)** | This up- and downside arrangement allows primary care providers with more capabilities to share in the savings to a greater extent while they are at risk for some losses, after meeting quality targets. | 3B |
| **Partial population payments for primary care** | This arrangement begins to introduce population-based capitated payments for primary care providers for a specific population of members they are treating. This arrangement is for selected providers who are willing to be partially paid for those specific primary care services. | 4A |
| **Shared-risk Capitation** | We share the member capitation payment with the provider and the provider is at risk for specifically designated services provided | 4B |

Aetna focuses on the following provider incentives:

- **Provider well-child incentive**: Intended to ensure child and adolescent members are seen by their primary care provider for recommended and timely screening and health services, this incentive

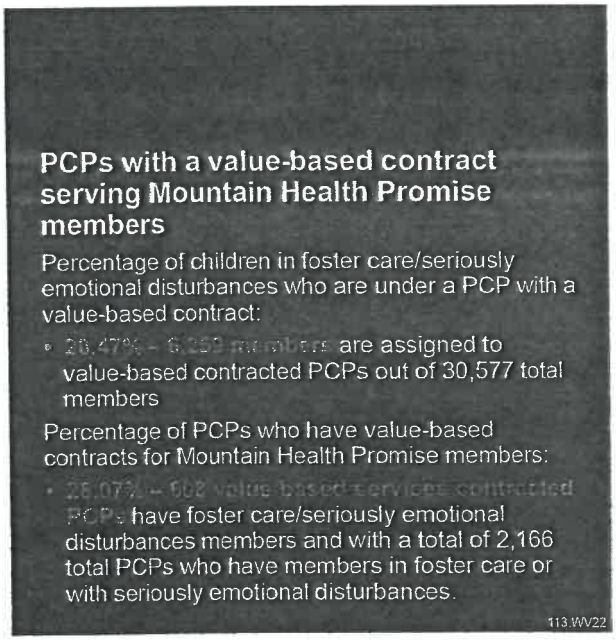
rewards the primary care provider with a payment of $25 per member for well-child visits for ages 12- 17 years.

- **Provider postpartum incentive**: Providers receive a $75 payment for each member who receives a qualifying postpartum exam in the 7- to 84 -day period after delivery We experienced an 11.64% year-over-year increase in our postpartum care HEDIS rate from MY2020 to MY2021.
- **Provider diabetic retinal eye (DRE) exam incentive**: Primary care providers are rewarded at the rate of $25 per member with diabetes ages 18 and older who receives a retinal eye exam. To support this initiative, we purchased five retinal cameras in 2022 and distributed them to provider offices that had a high-volume of diabetic members to help close care gaps.
- **Provider Performance incentive**: We determine key and impactable HEDIS measures selected for a provider bonus incentive once the finalization of HEDIS rates for the year. We set targets based on current goals, and providers can earn between a range of financial award amounts per measure depending on which target is met. Targeted 2023 measures include childhood immunization status, immunizations for adolescents, well child visits in the first 30 months of life, and eye exam for members with diabetes to correspond to positively impact prevention and to ensure healthy outcomes.

### Tracking costs and improvement in health outcomes through APM arrangements

Depending on the value-based contract, we compile and analyze results for outcomes by multiple departments, including quality metric targets, finance, and medical management. Results are then shared with the provider during regularly scheduled Joint Operating Committee meetings, and each contract may have a different standard for meeting frequency, either monthly or quarterly.

**Our quality metrics required for provider incentives and shared savings are individualized depending on the APM group. We support this individualization by maintaining close relationships with our providers and helping them review metrics and developing strategies for improvement.** Additionally, our provider services representatives meet with providers to address specific data trends in our Joint Operating Committees as well as during onsite provider visits. All providers can make data requests as well. We have learned through our experience implementing APM programs that we need to set reasonable and attainable performance targets, including measures of access, outcomes, quality of care, and saving. APM arrangements must be data-driven, based upon improvement opportunities via an analysis of claims, quality outcomes, SDoH, public health, and disparities data for each provider and model type.




If an unusual utilization trend is related to member behavior, we engage our Care Management team to assess if the members have the services and supports in place to meet their physical health, behavioral health, and SDoH, and help to resolve any barriers. We educate members on appropriate utilizations of ED services through outreach by care management, member newsletters, and the new member welcome book and provide tools for effective self-management. To assist providers with administrative

burden we will be introducing our White Glove model, which will identify our key providers who have large numbers of members. Once key providers are identified, this model assigns a local health plan representative who serves as the single point of contact and will assist with quality reviews, Joint Operating Committee meetings, and claims issues.

### Identifying and reducing inappropriate utilization of services through APM arrangements

Physicians play a pivotal role in improving quality, reducing costs and potentially preventable events, and ensuring efficient and effective use of health care resources. We help providers achieve these goals by developing financial models that reward physicians for quality and appropriate service utilization. **Our pay-for-quality (P4Q) program is designed to acknowledge and reward Medicaid providers with high clinical quality performance outcomes.** The model uses a framework of primary care providers with at least 100 assigned members. Providers must achieve certain metrics to be eligible for payment, including ER rate per 1,000, plan all cause readmission, readmission rates (TANF, SSI, and Affordable Care Act), and ambulatory emergency department (AMBED-ED) visit rate.

### Tying reimbursement to measurable outcomes and appropriate care

We aligned our profiling measures with our APM programming to incentivize the activities of the providers. Our P4Q program, which is part of our APM program, is an established program designed to acknowledge and reward Medicaid providers with high clinical quality performance outcomes. This model uses a framework of primary care providers with at least 100 assigned members. Providers must achieve certain metric targets to be eligible for payment. We have the flexibility to work with each unique provider practice to create a unique APM that works for both parties given West Virginia's unique environment. We are currently in negotiations with three provider practices to establish a new APM/VBP arrangement. As part of these negations, we are working to identify the most appropriate quality outcome measures applicable to their practice.

Aetna supports all providers interested in a stepwise approach from fee-for-service payments and succeed through APM. We have a vast amount of experience helping providers become more successful, both with increasing member satisfaction through better quality health care guided by our APM programs as well as with helping them increase their practice and fiscal goals. These payment models begin as departure from the traditional fee-for-service infrastructure and do so from least to most complex. This allows innovation in provider payment to promote the State's strategy to incorporate performance and quality initiatives in delivery models shown in **Figure E.7-2**

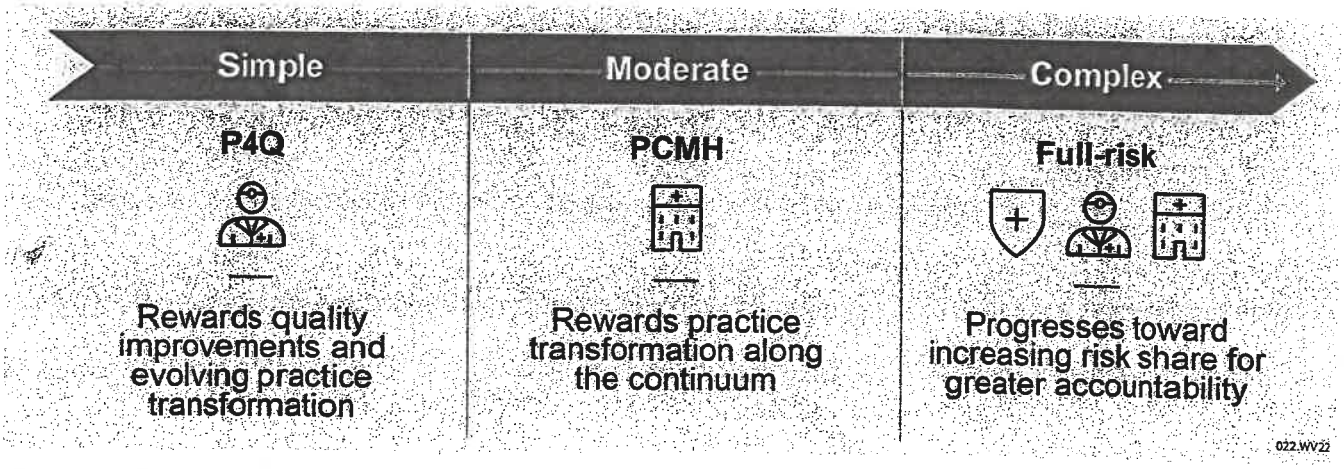
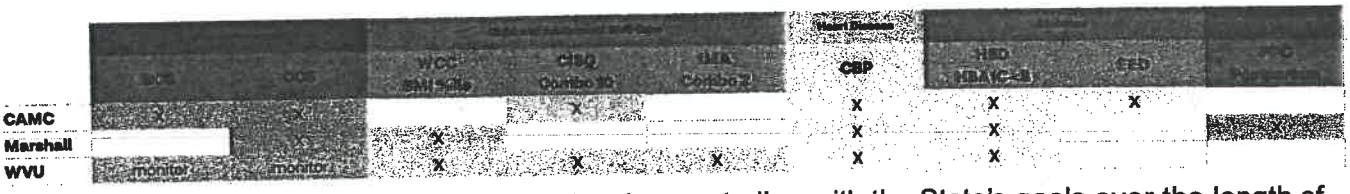



***Figure E.7-2** - illustrates our progressive array of provider payment model approaches.*

## Alternative payment models to increase quality and improve access [QU08, QU09]

Aetna has instituted a physician incentive plan contracting initiative within our value-based purchasing program, Aetna Better Value. Among the tools we use to achieve appropriate delivery of care and manage utilization of services, Aetna Better Value offers providers an array of Health Care Payment Learning and Action Network alternative payment models (HCP-LAN APM) designed to facilitate participation of providers—large and small, traditional, and non-traditional. From physician incentive plans with patient-centered medical homes (PCMHs)/advanced medical homes to shared risk and then to full-risk capitation, we work toward having most of our network providers successfully moving across the value-based continuum within the HCP-LAN framework. **We place emphasis on advancing providers through the APM continuum to Categories 3 and 4, which include upside gainsharing, downside risk, and condition-specific population-based payments and other incentives. As providers evolve along the APM value continuum, we link incentives to improved quality, cost savings and reductions in inappropriate utilization of services, including, but not limited to, inappropriate admissions and readmissions, and increased member satisfaction and engagement.** For example, we have recently added a new shared savings agreement with Charleston Area Medical Center and West Virginia University Hospital System Please see image below.




Aetna's goals for APM implementation and development align with the State's goals over the length of the contract. As a result, our models are flexible, and metrics can be modified to ensure we meet objectives. Aetna is fully committed to collaboration with the DHHR and other vendors in developing and implementing an APM in West Virginia. The Aetna enterprise has developed over 1,900 arrangements of all types within the HCP-LAN APM continuum and over 7 million members in various APM arrangements across all lines of business. Through Aetna Better Value, our Medicaid suite of APM solutions, our physician incentive strategy supports delivery system reform and practice transformation. Aetna has been highly successful building on a national record of success in payment reform. As providers evolve along the HCP-LAN APM continuum, we link more provider payments and incentives to value and realize improved quality, reduced costs, and increased member satisfaction and engagement. We also leverage our national and West Virginia commercial and Medicare enrollment to encourage providers delivering care to all product lines to accept physician incentive plans. We report annually to the State our activities related to APM structures for the providers with whom we have direct contract oversight.

### Provider incentives

We create aligned incentives between the State, county, member, and provider, which ensures that all parties are working toward the same goals. Our value-based contracting arrangements incentivize and support providers in adopting and adhering to evidence-based guidelines. Our value-based payment program is informed by the QAPI and is focused on quality outcomes (HEDIS, CAHPS, reduction in health and social disparities, and inappropriate utilizations) and State goals. Programs are selected for providers based on practice size and specialties, membership panel and population, level of sophistication and engagement, and clinical and technological capabilities.

Our physician incentive plans are data-driven, based upon improvement opportunities identified via an analysis of claims, quality outcomes, SDoH, public health, and disparities data for each provider and model type. **These physician incentive plans align with the HCP-LAN APM framework of 2A, 2B, 2C, 3, and 4 with direct linkage to the provider-specific and applicable quality performance measures. Aetna's physician incentive plan approach includes primary care and specialty care (including behavioral health and hospital-based care) and expands into other treatment venues, such as community mental health centers, FQHCs, rural health centers, and non-traditional providers.** Our unique approach with these providers increases improvement in the health of West Virginians through innovative, whole-person care and well-coordinated systems of care addressing medical and non-medical drivers of health. We have collaborated with the provider community to advance the West Virginia health priority of implementing delivery system reforms to improve quality and outcomes and the reduction or elimination of health disparities through our innovative physician incentive plans.

Aetna focuses on the following provider incentives:

- **Provider well-child incentive**: Well child gaps-in-care lists are sent to the primary care provider on record quarterly. These lists include our members aged 12-17 years who have not had a well-child visit in the prior 12-month period. Each quarter, a query is run to identify any qualifying well-child claims. Claims are then matched to the members identified on the gaps-in-care lists sent to the offices. A well-child claim is considered qualifying if it is billed with an appropriate ICD-10 or CPT code and is performed by a provider with a primary care specialty. Incentives are paid at $25 per member. An incentive is only payable one time per year. Payment goes to the primary care provider on record to whom the letter was sent or at the group level for that office. If another provider/practice performs the service, no incentive is paid.
- **Provider postpartum incentive**: Postpartum letters are sent monthly to the last OB/GYN seen by the member and include all deliveries from the prior two-week period. Each quarter, a query is run to identify any qualifying postpartum claims. The first qualifying claim received is paid to the rendering provider/practice. Postpartum claims are considered qualifying if they occurred in the 7- to 84 -day period after delivery and were billed with a CPT code of 59430. Incentives are paid at $75 per member. We had an 11.64% year-over-year increase in our postpartum care HEDIS rate from MY2020 to MY2021.
- **Provider diabetic retinal eye (DRE) exam incentive**: DRE gaps-in-care lists are sent to the primary care provider of record quarterly. These lists include our members aged 18 years old and older with diabetes who have not had a dilated eye exam in the prior 12-month period. Each quarter, a query is run to identify any qualifying eye claims. Claims are then matched to the members identified on the gaps-in-care lists sent to the offices. A dilated eye exam claim is considered qualifying if it is billed with an appropriate ICD-10 or CPT code and is interpreted by an eye care professional. Incentives are paid at $25 per member. An incentive is only payable one time per year. Payment goes to primary care provider of record to whom the letter was sent or to the practice, if applicable.
- **Provider Performance incentive**: Key, impactable HEDIS measures selected for a provider bonus incentive are determined once the HEDIS rates for the year have been finalized. We set base targets on current goals, and providers can earn between a range of financial award amounts per measure depending on which target is met. **Targeted 2023 measures include childhood immunization status, immunizations for adolescents, well child visits in the first 30 months of**

**life, and eye exam for patients with diabetes, and correspond to positively impact prevention and to ensure healthy outcomes.**

## Improving access

| | |
|---|---|
| QU13 | The Vendor should report annually to the Agency on its activities related to statewide availability and access to care, according to Appendix 3: Service Provider Agreement (SPA). The Vendor should describe how it will meet this specification. |
| QU14 | The Vendor should use data to identify barriers for access to care for children and youth including children with special healthcare needs to improve outcomes including, but not limited to, the following data collection methods:<br>• Focus groups<br>• Surveys<br>• "Secret shopper calls"<br>• Aggregate utilization monitoring<br>• Complaints and grievances<br>• PCP change requests<br>• Out-of-network referrals<br>• Emergency room (ER) usage<br>The Vendor should describe in detail how it will meet these specifications. |
| QU22 | The Vendor should provide data to identify members in populations eligible for medical services that reflect a gap in annual primary care services, to include but not be limited to EPSDT services. The Vendor should contact a member and the member's PCP within a set time frame after identifying that the member has not received primary care services. The Agency may request, at no additional cost to the State, that the Vendor provide raw data at a child level directly to the State at a frequency to be determined by the Agency. The Vendor should describe: 1) Types of data the Vendor will use to determine which members have/have not received primary care services; 2) Any other mechanisms the Vendor will use to determine which members have/have not received primary care services; 3) Who is responsible for tracking this data; 4) How frequently the Vendor will run this data<br>5) Who will contact the member and the member's PCP |

## Activities related to statewide availability and access to care [QU13]

We ensure that all covered services, including additional or supplemental vendor or contracted services provided to members, are available and accessible as required in 42 CFR §438.68, §438.206, and §438.207 and complies with Section 3 of the Model Purchase of Service Provider Agreement. We conduct various activities statewide availability and access to care.

**Network availability assessment.** The purpose of this annual analysis is to assess the adequacy of our practitioner network to meet the members' needs based on the travel distance from the member's home, the percentage of practices that are closed to new members, and the practitioner to member ratio. The evaluation includes an assessment of primary, specialty, and behavioral health practitioners in accordance with the standards developed by the West Virginia BMS and our policies to ensure members have access to needed services and to identify opportunities to enhance availability and grow the network based on member need.

**Network appointment availability.** The purpose of this annual analysis is to provide a comprehensive assessment of primary care, specialty care, and behavioral health appointment accessibility as well as after-hours accessibility in accordance with the State's contractual requirements, accreditation standards, and Plan policy.

In addition to these annual assessments, we also use member complaints and appeals as a tool to identify potential issues with network adequacy. The Appeals Committee meets weekly, and the Complaint Committee meets at least every two weeks. During these committee meetings, trends in

practitioner or facility access or availability would be identified and addressed. Reports on these activities is presented to the local Service Improvement Committee.

Lastly, another key tool to evaluate member access and availability is through the CAHPS member satisfaction survey. Aetna received excellent rates in both 2021 and 2022. The child CAHPS scores are at or above the 90th percentile nationally for getting care quickly, access to routine appointments, and access to urgent appoints as noted in the table below.

| Measure | 2022 Rate and Percentile | 2021 Rate and Percentile |
|---|---|---|
| **Getting Care Quickly Composite Score** | 95.55% (95th percentile) | 95.16% (95th percentile) |
| **Access to Routine Appointments as soon as Able** | 95.1% (95th percentile). | 92.5% (90th percentile) |
| **Access to Urgent Appointments as soon as Needed** | 96.0% (95th percentile) | 97.9% (95th percentile) |

## Identifying barriers for access to care for children and youth including Children with Special Healthcare Needs [QU14]

At Aetna, children and youth including Children with Special Healthcare Needs (CSHN) are identified by the enrollment file sent by the State, internal claims data, or the health risk assessment.

For children and youth and the CSHN population, we assign a care coordinator to assist and support the individual and their family in addressing potential barriers to care. The care coordinator assists the family by coordinating care and ensuring that all necessary services, including SNS, are made available. We hire care coordination staff who are local, including community health workers and peer support specialists, with backgrounds and/or lived experience to foster building relationships with members based on mutual trust and respect. We match members to the care coordinator with the most relevant expertise and/or licensure (e.g., mental illness, child welfare system) and who can meet their cultural, language, and communication preferences.

**Membership data for the past three-year period shows a year-over-year increase in the number of children identified with special health care needs.** Drill-down of this population revealed the highest number reside in Kanawha, Cabell, and Wood counties. Care Coordination teams covering those counties can pinpoint resources available to meet various health and wellness needs. Care Coordination team members also conduct face-to-face visits with these children to facilitate care management and address barriers in a timely manner.

Aetna uses GeoAccess reporting to identify specific areas or regions that may lack an adequate network of providers trained to work with children and youth. These reports assist in targeted outreach to potential providers and help to develop a network of providers for this specialized population. In addition, we use information gleaned from member input (such as member surveys, focus groups, and our Member Advisory Committee) to assist in identifying any potential barriers that children and youth may experience. Focus group topics include access, service delivery, gaps in support systems, engagement with system staff, cultural competency, and consumer knowledge of services and supports,

### Using focus groups to identify barriers to care for individuals with special needs

Although we communicate with and assist individual members regularly, we recognize the power of hearing firsthand stories from individuals who have been directly involved in the foster care and adoption assistance systems, outside of our direct member interactions. The Member Advisory Committee assists in this process by soliciting member feedback and opinions regarding issues related to access and the quality of care and services provided to members as well as potential programs, activities, and educational materials. Our care advocate team (CAT) administrators, specifically the

child CAT and recovery and resiliency CAT administrators, coordinate multiple member-focused coalitions that include members and their families and caregivers.

We engage the families and caregivers of CSHN through focus groups monthly, as outlined in the Model Purchase of Service Provider Agreement. We use these opportunities to hear from those impacted by the foster care system firsthand and develop collaborative solutions that address the unique situations facing this population. We meet with the BSS monthly, where we can collaborate and discuss potential topics for focus groups to make certain useful information is collected. These interactions can also help Aetna identify ways to advance the Family First Prevention Services Act across the state and help to ensure the collection of information useful to us and our key stakeholders, such as BSS.

We are required to contractually conduct six focus groups, however, have been targeting 12 focus groups throughout the year with youth, families, and foster and adoptive parents that reside in the community and use socially necessary services. **The focus groups are an opportunity to provide the DHHR with feedback on where services are being most impactful, so programmatic changes can be made to improve the overall health of the program.**

## Using member satisfaction surveys to identify barriers to care for individuals with special needs

Aetna uses the CAHPS survey tool to collect information about consumer-reported experiences with health care. The survey measures how well the health plan is meeting members' expectations, which Aetna uses to identify areas of opportunity for improvement that would positively impact member outcomes and improve the quality of care and service delivered to members. We provide survey results to both members and practitioners to promote ongoing continuous quality improvement.

The Quality Management department, as part of the quality management/utilization management program evaluation, conducts retrospective reviews to compare satisfaction ratings for the special needs population as compared to the aggregate scores. Aetna regularly tracks and monitors accessibility of services, and with the identification of special needs population, via the DHHR's enrollment information identifying CSHN. The CAHPS survey captures data related to appointment availability, which is used to identify and address any barriers to care for children with special needs. At implementation, Aetna expanded our surveys to include use of the CAHPS survey item set for children with chronic conditions. We have experience using the CAHPS item set for the children with chronic conditions survey and implement this targeted survey to identify barriers to care for individuals with special needs. The table below highlights CAHPS scores related to members getting needed care and services showing improvement from 2021 to 2022.

| Measure | 2022 Rate and Percentile | 2021 Rate and Percentile |
|---|---|---|
| **Getting Needed Care Composite Score** | 91.69% (90th percentile) | 91.61% (75th percentile) |
| **Easy to Get Care, Tests, or Treatment that was Needed** | 94.9% (95th percentile). | 93.2% (75th percentile) |

This version of the CAHPS survey expands beyond the standard CAHPS child survey to assess areas related to health providers, including contacting schools or daycare centers about the child's health, special medical equipment, special therapy such as physical/occupational/speech therapy, and offerings of counseling for emotional, developmental, or behavioral problems.

In addition, **we capture member satisfaction through the behavioral health member satisfaction survey, which evaluates member experiences for behavioral health care services, including questions related to member experience with accessibility, communication, practitioner**

**satisfaction, member services, and overall satisfaction with behavioral health care services.** Based on our findings, we implement interventions and improvements to meet the needs of our members. For example, as part of our focus on addressing the concerns of members with behavioral health needs, Trauma Informed Care training is part of our colleague onboarding program as well as a component of monthly in-service training that all member-facing clinical staff receive monthly. We have also augmented our staff with the implementation of a Peer Support program, pairing members with a staff member who has lived experience.

Aetna also uses information from complaint and appeals data for trending and analysis in conjunction with member survey data in the assessment of opportunities for improvement and for the development of action plans for both physical and behavioral health.

### Using Secret Shopper calls to identify barriers to care

Aetna has experience with conducting secret shopper calls to identify barriers to care and have used them to specifically target providers serving the CSHN population. Panel and claim reports can be used to identify providers who meet a set threshold volume to conduct. We conduct calls at a set frequency throughout the year. The Provider Relations staff can facilitate calls to practitioners that have treated our CSHN members to ensure appointment availability exists for routine, urgent care, and follow-up visits as required by the contract.

In addition, Aetna's provider relations department conducts an annual provider fax survey to all providers who have been in the network for at least six months. A part of this survey focuses on the provider's accessibility and availability of appointments. For new network primary care practice sites, Aetna conducts an onsite initial credentialing visit, during which the Provider Relations department queries staff about accessibility and availability of appointments. For providers serving children with special needs, there may also be additional target population-specific survey questions to help ensure accessibility and availability standards are being met. Providers not meeting standards receive education. We provide additional follow-up after education to ensure required processes have been implemented. If the provider is still not meeting standards, our contracting team reaches out to the provider for a response. The provider may be asked to create a corrective action plan, and results are then reported to the Service Improvement Committee for further action, including possible termination.

### Using aggregate utilization data to identify barriers to care for individuals with special needs

Aetna uses multiple data sources to monitor appropriate health care utilization. We use utilization management reports and dashboards to monitor utilization data to identify trends that fall outside defined parameters and take action to address the trend. Understanding the needs of members in real time helps to inform where we may need to implement interventions. **We use utilization management reports and dashboards to monitor utilization data to fully understand the current trends of where and how members are seeking care. Aetna assesses utilization rates using our Quality Performance Management System, which gathers data from various sources including medical, behavioral, and pharmacy claims and authorizations, operations metrics, and electronic visit verification data.** The system is the backbone of our utilization data reporting. We track trends and risks to detect potentially preventable events, outlier facilities and primary care providers, specialists with unusual trends, fraud, waste, and abuse, under- and over-utilizing members and cohorts, condition-specific outliers, and unexplained regional variances.

When we see these trends, we collaborate with the provider to identify the root cause and develop an intervention to address the trend and then monitor to assess the effect. Specifically, we use this

aggregate utilization data to identify opportunities to isolate/pinpoint and address barriers to care for individuals with special needs. Some utilization management metrics tracked and used to identify barriers to care include average length of stay for both behavioral health and PH, total readmission rates, and acute behavioral health and physical health bed days. CAT staff, including the child and adult CAT administrators, meets routinely with the network director and provider services liaison to review network adequacy data, identify opportunities for network enhancement and growth, and review the status of the recruitment plan. An example of how we use aggregate data is through our APM arrangement monitoring. **We found a substantial decrease in membership ED utilization per 1,000 with Charleston Area Medical Center, demonstrating a positive impact with our APM partner provider.**

We have an extensive suite of utilization management dashboards and reports with near real-time data to monitor appropriate utilization of services and cost-efficiencies. The Quality Performance Management System supports generation of a suite of state-specific reports to provider partners and internal colleagues to improve quality. These standardized routine reports are focused on our targeted categories for identifying over-utilization and include the following:

- **Demographic distribution for ED utilization dashboard**: This dashboard allows users to review ED utilization data through a demographic and health equity lens. The dashboard sorts and filters members' ED utilization data to identify possible demographic-related disparities related to race, ethnicity, language, geography, or adverse incidents. We map where high ED users reside, which allows us to assess local hospitals, urgent care centers, and providers with after-hours care to divert members to those services when possible. This process provides for a region-specific, targeted approach to ED diversion.
- **Utilization management performance dashboards**: We developed and use a suite of utilization management dashboards to identify under- and over-utilization of services and engage care coordinators to perform outreach to the members for immediate intervention.
- **Pharmacy data analysis**: We conduct retrospective reviews to assess over- and under-utilization patterns to drive the development of interventions and/or educational activities.
- **Gaps-in-care reporting:** As both an internal and external tool to address under-utilized services. These monthly reports will enable providers to identify gaps early and implement interventions to close the care gaps. In addition, we evaluate gaps in care with every member interaction, encouraging needed care such as screening, well visits, or follow-up care.

### Using data to identify access barriers to care for individuals with special needs

Aetna engages in an accessibility analysis for both physical health and behavioral health providers. The tools used to monitor accessibility include the CAHPS member satisfaction survey, the annual behavioral health survey, the practitioner appointment accessibility fax survey, member complaints related to accessibility of practitioners/providers, and office site visits conducted during the credentialing process. Aetna expands the use of these surveys to collect data to identify access to care barriers for individuals with special needs.

Aetna's network director identifies network gaps and opportunities for improving and monitoring to make sure identified needs are promptly acted upon. **CAT staff, including the child and adult CAT administrators, meets routinely with the network director and provider services liaison to review network adequacy data, identify opportunities for network enhancement and growth, and review the status of the recruitment plan.** In instances where members are not able to make appointments with the appropriate provider, Care Coordination teams and member services representatives step in,

facilitate the request, and even make the appointment if necessary. In addition, if a provider is attempting to help a member get an appointment with another provider, provider services staff can assist with scheduling that appointment so the member can receive the care in a timely manner.

Aetna implements steps to support compliance with required time, distance, and appointment wait time standards as outlined in Section 3 of the Model Purchase of Service Provider Agreement. If a contracted provider does not comply with these standards, we meet with the provider face-to-face, and we also take corrective action through our Quality Management program and committee structure.

For providers not meeting accessibility requirements, they receive education regarding appointment accessibility standards. We provide additional follow-up after education to ensure the required processes have been implemented. If the provider is still not meeting standards, our Provider Relations team reaches out directly to the provider for a response. The provider may be asked to create a corrective action plan, and results are then reported to the Service Improvement Committee for further action, including possible termination.

### Tracking and trending complaints and grievances for individuals with special needs

Through our robust committee structure, we review trends related to CSHN, including those involved in the foster care system and adoption assistance programs. Quarterly, we review our grievance and appeals report in the local Service Improvement Committee to identify trends related to barriers to care for these populations. We compare these rates to the children and adolescent populations across the year. When we identify trends, the committees take action to help ensure these issues are addressed promptly and directly with the providers through education and possible corrective action plans. Analysis of the complaints revealed no concerns involving families with CSHN.

We maintain records of all appeals, grievances, and State Fair Hearings within our internal, proprietary application. **Our reporting suite enables us to monitor aging of cases in real time to make certain of timely resolution and to identify and report trends for potential opportunities for improvement.** In addition, we can identify complaints and grievance information directly pertaining to the CSHN populations to help ensure timely response to issues. Appeals and grievances files are maintained in a secure manner and are accessible to the DHHR, its designee, or CMS upon request. We retain appeal and grievance files for the longer of 10 years following the final decision, or 10 years from the date of the expiration or termination of this contract.

We capture this documentation both to meet the State and federal requirements, and because it allows us to maintain and track all cases from origination through resolution/decision. Our system contains a standard suite of reports and queries by case type of complaint, appeals, grievance, or State Fair Hearing that we used to track cases throughout the process. To support the accuracy and integrity our appeal and grievance data and reporting, Aetna has programmed our appeal and grievance application to automatically calculate the due date for completion of the case to avoid data entry or staff errors in calculating due dates. The application uses this due date when calculating the actual turnaround time on completed cases, and upon resolution, automatically marks the case as timely or untimely.

The appeal and grievance supervisor uses standard queries and reports within the application to monitor cases in real time to make certain of timely and accurate resolutions, and to manage staff workloads, including reassignment of cases during unscheduled absences such as staff illness. If we see any evidence of an issue requiring escalation, we act on it immediately. For example, the aging report displays all cases in real time and gives the age from received date and time to date and time of report run in calendar days. All follow-up actions such as members' phone calls and the overall age of the case are color-coded in each staff person's work queue. **The daily case work queue for each**

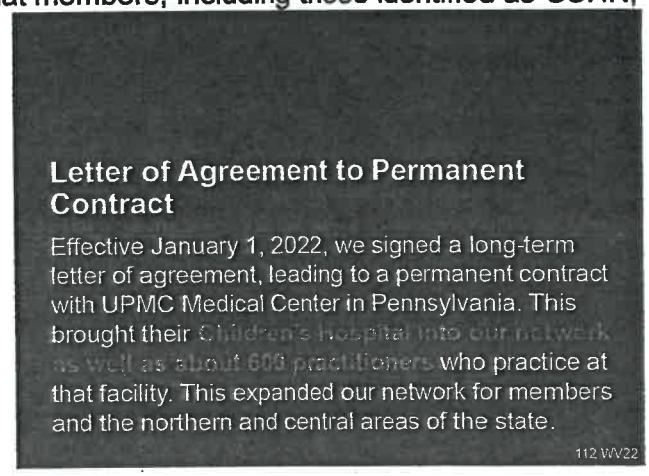
**representative is set up so that past due cases display in red, those due in 48 hours display in blue, and those due in greater than 48 hours display in black.**

### Tracking members requesting changes in PCPs for individuals with special needs

Aetna currently tracks members selecting different providers through our call tracking process and primary care provider change reports and we track this movement between primary care providers for the CSHCN population. When members or their caregivers and guardians request to change their primary care provider, the Member Services team selects the appropriate reason code for the change and completes a real-time change of primary care provider assignment while the member and/or guardian is on the line. If we identify a potential accessibility issue through a member's request to change primary care providers, we immediately address the issue and refer it to the Provider Relations team to act. In addition, we continually monitor terminated primary care providers, and for CSHCN we transfer members to appropriate primary care provider to help ensure continuum of care.

### Tracking barriers for out of network referrals for individuals with special needs

Aetna's overall goal within this process is to assure that members, including those identified as CSHN, receive continuity of care. Occasionally, we refer a member to an out-of-network provider/practitioner because of special circumstances, specific qualifications of the out-of-network provider/practitioner, or because of a pre-existing relationship with an out-of-network provider/practitioner. We track barriers not only through our claims, but through our GeoAccess and drill-down reports. These additional reports assist in identifying trends for out-of-network referrals in certain regions and allow us to engage additional providers in the area to initiate contracts within our network. An example of how we remedied an identified gap in care in the Eastern Panhandle area. We discovered there was no inpatient behavioral health facility for children ranging in age from 5 to 14 years, and so we reached out and initiated a contract with an inpatient facility meeting this need: the Alice C. Tyler Village of Childhelp East, located in Lignum, Virginia.




### Tracking access to emergency department use for individuals with special needs

Medicaid members, including CSHN, tend to visit the ED more often than non-Medicaid members because they often have higher rates of chronic disease and more co-occurring physical and behavioral health disorders. In addition, these members have barriers stemming from SDoH. We help the CSHN population access the primary and preventive care they need to avoid medical or behavioral health crises that result in avoidable ED usage. Aetna's current utilization management dashboards allow drilldown monitoring of ED usage by various parameters including age, gender, geographic region, and other membership characteristics. This data is used to track access to ED use for individuals with special needs.

**Members with special health care needs who seek non-emergent care in an ED are not receiving the benefit of a medical home and the continuity and familiarity that a primary care provider or the appropriate specialist provider can offer. Our goal is to assist these members with identifying and removing barriers.** The following innovative solutions and flexible approach to

integrated care management provide unique opportunities for improved health outcomes that meet and exceed State expectations and address inappropriate ED use by care coordinators:

- **Accessing informatics reports** that identify members with special health care needs (flagged in our internal data management system) who have used ED services
- **Outreaching to CSHN members** to educate them on ED use and when it is appropriate to use the ED versus urgent care or primary care provider/specialty provider and give information on the 24-hour Health Information line (Nurse Line)
- **Identifying barriers that prevent these members** from receiving care in their medical home or outpatient specialist office, such as transportation, work schedules, or social support. Care coordinators work with members and their guardians to reduce and/or remove the barriers.
- **Identifying practice trends** that affect members' ability to receive care in a medical home

## Using data to identify members who still need primary care services [QU22]

We assign every Mountain Health Promise Program member a case manager who works directly with the member and their family on an ongoing basis to ensure compliance with recommended primary care screenings. The case manager offers appointment reminders and follow ups on missed appointments. Our internal data management system flags members are based on the enrollment file sent to us by the State.

In addition to the ongoing outreach by the case manager, the Quality Management department also provides monthly gap in care reports to primary care providers based on claims data. This data can also be used to determine if a member may be going to another physician or urgent care for these services, so they can be re-directed to their primary care provider or assigned to the new primary care provider of attribution. We use the West Virginia Health Information Network (WVHIN) to assist in providing data for providers treating foster care youth. We retrieve this data from WVHIN regularly to help us identify, in a timely manner, members who have not been seen by their primary care provider within the set timeframes. **In November 2021, we launched an updated portal system that allows more streamlined access to our data. In the case of lags in claims data, we can pull data from the WVHIN to help proactively address gaps in care.**

### Contacting Members Who Have Not Received Primary Care Services

Aetna believes in a proactive approach to ensuring members receive primary care provider services in a timely manner. Our system flags members to receive outreach from a Care Management staff member within 24 to 48 hours of receipt of the monthly enrollment file from the State. We assign all youth entering the foster care system to the Care Management team and we stratify them into one of three tiers, depending on severity of issues. Tier 1 members (lowest level of severity) receive at least a quarterly outreach call from the Care Management team along with at least one interdisciplinary care team meeting per quarter. Tier 2 and Tier 3 members receive more intensive outreach depending on the situation. All outreaches by the Care Management team provide additional opportunities for the member and/or caregiver to be reminded of the importance of receiving timely primary care services. Another way that we monitor member experience with appointment accessibility is through the CAHPS survey as noted in the table below.

| Measure | 2022 Rate and Percentile | 2021 Rate and Percentile |
|---|---|---|
| **Getting Care Quickly Composite Score** | 95.55% (95th percentile) | 95.16% (95th percentile) |
| **Access to Routine Appointments as soon as Able** | 95.1% (95th percentile). | 92.5% (90th percentile) |
| **Access to Urgent Appointments as soon as Needed** | 96.0% (95th percentile) | 97.9% (95th percentile) |

Care Management staff verify primary care provider assignment, inquire about most recent visits, encourage necessary well-child visits, and confirm that members have access to a complete, up-to-date list of network and SNS providers. If the member or caregiver is not reached during the initial outreach call, we send a letter to the member containing information related to services and a reminder to make their primary care provider appointments. In addition, we include the members identified as not having received timely primary care services in upcoming well-visit events at local primary care sites where the Quality Management team makes direct member outreach telephone calls to these members.

### Contacting PCPs for members identified as not receiving primary care services

Aetna helps ensure that primary care providers are aware of their assigned panel and each contracted provider has access to our provider portal where their membership panel may be reviewed and extracted at any time. To proactively notify and make certain primary care providers are aware of the access and reporting guidelines for these populations, our Provider Relations staff provide them with informational fliers, along with monthly provider trainings for provider office managers. Depending on the age of the member and their need, we send out monthly letters notifying the primary care provider which members are overdue for an EPSDT visit or additional well-child follow-up.

### Reports about members who have not received primary care services

Aetna uses aggregate claims data related to primary care provider services to help identify members who may be missing critical appointments and screenings. Quarterly, we generate reports for our primary care providers to identify any children and youth in their practice who are overdue for their wellness appointments. The reports include the names and contact information of all children and youth who need services. The quality management team also uses this information to identify provider offices for direct outreach and an offer to conduct a well-visit clinic drive at their facility. We work collaboratively with our Care Management department to conduct necessary outreach to the member and their families and caregivers who have not been seen by their primary care provider. This outreach includes conversations surrounding barriers to accessing care, and, if barriers to access are discovered the team supports the family in acquiring necessary supports to ensure access. Raw data at the child level at is available to the State upon request based on their determination of frequency.

## Regulatory Reporting / Performance Measurement

| | |
|---|---|
| QU06 | The Vendor should use Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families. The vendor should report these measures to the Agency according to the requirements in Appendix 3: Service Provider Agreement (SPA). The Vendor should describe how it will meet this specification. |
| QU07 | The Vendor should use measures beyond Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families. The Centers for Medicare and Medicaid Services (CMS) Core Set of Children's Health Care Quality Measures and American Dental Association (ADA) dental quality measures are mandatory for the program. The vendor should report these measures to the Agency according to the requirements in Appendix 3: Service Provider Agreement (SPA). The Vendor should describe proposed measures beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS). The Vendor should also describe its procedures to meet the. The Centers for Medicare and Medicaid Services (CMS) Core Set of Children's Health Care Quality Measures and ADA dental quality measures. |
| QU18 | The Vendor should establish and collect member satisfaction measures following the implementation date. 1) The Vendor should provide proposed member satisfaction measures; 2) The Vendor should describe past Vendor efforts to assess member satisfaction; 3) The vendor should provide a detailed report based on member satisfaction responses to the Agency. |

## Using HEDIS scores and other performance indicators to access our program [QU06]

Aetna uses HEDIS and other performance indicators to assess our program and policy impact on West Virginia's youth and families. We have a proven capacity to participate in the annual HEDIS and non-HEDIS performance measurement and reporting initiative as evidenced by our timely submission in West Virginia to NCQA and State regulatory agencies for HEDIS 2016 through HEDIS 2021. The table below depicts examples of our Mountain Health Promise HEDIS scores above the national average.

| Measure | National Average | HEDIS MY2021 |
|---|---|---|
| **Annual Dental Visit—Total** | 47.39% | 62.7% |
| **Lead Screening in Children** | 62.23%% | 64.48% |
| **Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase** | 50.0% | 60.51% |
| **Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase** | 39.68% | 52.26% |
| **Immunizations for Adolescents—Combo 1** | 77.73% | 80.54% |
| **Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total** | 36.57% | 71.35% |
| **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI% Total** | 76.14% | 82.48% |
| **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Total** | 69.2% | 77.13% |
| **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Total** | 65.75% | 76.40% |
| **Child and adolescent well-care visits (total)** | 49.55% | 58.38% |
| **Well-care visits in first 30 months of life (15 – 30 months)** | 66.04% | 81.01% |

At the close of each review cycle, our contracted NCQA auditor validates our HEDIS data files. The chief executive officer designates the chief medical officer/medical director to direct the initiatives and see that they conform to State, federal, local, and Aetna organization mandates. Under the chief medical officer/medical director's direction, the West Virginia Quality Management department caries out HEDIS activities and interventions with support from the national Aetna team. Improving HEDIS and other performance indicator rates are a company-wide endeavor, with operating responsibilities shared by departments designated by the chief executive officer. We report our final audited HEDIS measures annually to the State by June 15th.

All departments involved in HEDIS, or other performance measurement activities comply with federal, state, and local privacy regulations during review and/or transport of medical records and information. We incorporate HEDIS activities and performance measurement goals into the annual QAPI work plan. Analysis and comparison of performance results to national benchmarks provides the basis for the design and implementation of appropriate interventions. Aetna's Health Equity HEDIS dashboard identifies and measures health disparities of our members by stratifying HEDIS measure rates by race, ethnicity, gender, and age. **The dashboard provides intuitive data visualization, reports, predictive analytics, and time series forecasting that enables us to do the following:**

- Identify populations with disparities and provide actionable insights
- Track and monitor effectiveness of programs and interventions
- Implement clinical interventions
- Conduct member outreach
- Inform value-based contracting

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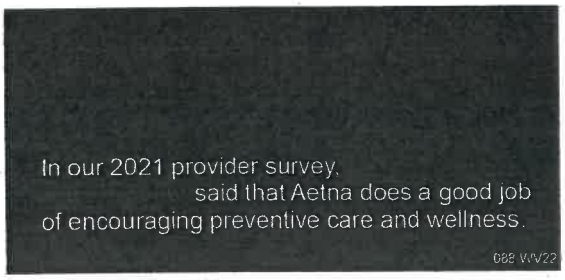
## Measures Beyond HEDIS to Assess Program and Policy Impact on West Virginia's Youth and Families [QU07]

Aetna recognizes that having a meaningful impact on the health outcomes of West Virginia members goes beyond improving performance on these traditional HEDIS scores. We collect data on CMS Core Set of Children's Health Care Quality Measures and American Dental Association dental quality measures and report them to the State on or before September 1st as required. Efforts beyond HEDIS measures include supporting children and families through family engagement that emphasizes primary prevention and early intervention. This approach drives our CAT model incorporating our whole-person, whole-family approach to physical, behavioral, and social well-being. We closely monitor our care management, care coordination, and utilization management services and policies to align to our person-centered model of care. This process promotes the best possible outcomes for West Virginia members and their circle of support.




At Aetna, we measure outcomes at all levels of care, management, and leadership. When we do not achieve desired outcomes, we make corrections a quickly. Aetna uses measures beyond HEDIS that assess the outcomes related to care management, care coordination, and utilization management. These measures help ensure the clinical models of care have a meaningful impact on the health outcomes of members and their families.

### Care management services and policies

**The Charting the LifeCourse™ framework focuses on serving members and families in concert with their circle of support.** This framework will be made available to entire care coordination team via FamilyConnect 2.0. We provide links to the Charting the LifeCourse™ website in our care coordination application, FamilyConnect 2.0, where the caregiver or care coordinator will find several outreach tools available for completion. These can then be uploaded into the FamilyConnect 2.0 care documents repository facilitating access for the entire care coordination team. Children and youth involved in the foster care system may not have birth families actively participating in their care. By using the framework and engaging additional informal supports, these children and youth are surrounded by individuals invested in their overall quality of life. This framework creates and documents a single care plan that addresses much more than covered services and paid/unpaid support. The care plan also addresses the members' likes and dislikes, gaps in care, and life goals and objectives that promote self-efficacy and personal satisfaction, living in the community of their preference, and participating in socially rewarding life activities. The LifeCourse framework focuses on the member's circle of support and assists them to identify what they need to be successful. **We address all challenges by engaging the child's circle of support, including biological parents, adoptive parents, relatives, foster parents, or other caring adults in a collective approach to family safety, healing, and thriving.** We commit to improving outcomes for members and their families and have added APM arrangements to contractually incentivize recommended outcome measures.

Aetna's tiered care management approach moves through the continuum from low risk (general population) to high risk—our most intensive care management for the most vulnerable members with biopsychosocial complexities. The model identifies people at risk of high cost and/or high utilization in the future by using medical, behavioral, laboratory, dental, and pharmacy diagnoses and claims data, and the likelihood of integrated care management making an impact. The risk rankings feed directly into our electronic care management platform to identify and prioritize members for outreach into intensive

or supportive care management as well as those who would benefit from chronic condition management. Our care coordinators act as the single point of contact for the members, family, and entire circle of support, resulting in less system confusion, more connection to high-quality services and supports, and increased satisfaction.

**At case closure, we ensure a successful transition including oversight and planning related to housing, nutrition, education, and employment (if applicable), whether it is to biological, kinship care, adoptive, or foster parents. Post-case closure, we remain available for assistance and continue to track the child's outcomes.** Our experience shows that most children involved in the foster care system remain eligible for Medicaid benefits, creating the need for effective health care access as well as transitions to stable housing, employment/employment training, and/or educational services. The table below outlines our recommended measures to determine if care management is having a meaningful impact on the health outcomes of members and their families.

| Care Management Measure | Description |
|---|---|
| **Rate of grievances and complaints** | Having a single point of contact for issue resolution will result in fewer grievances and complaints. |
| **Rate of adverse outcomes/potential quality of care concerns** | The dedicated care coordinator will work to understand the family's needs, connect them with high-quality evidenced based treatment in their community, and be the first point of contact to resolve any issues or barriers. |
| **Results from the CAHPS adult and child survey** | Close communication and coordination with the dedicated care coordinator will result in high rates of satisfaction as gathered from the CAHPS adult and child survey. |
| **Percent of children/youth that stay engaged with services past age 18** | The care coordinator will build a relationship with the children/youth and family to encourage ongoing participation in services past age 18. |
| **Percent of children completing EPSDT appointments per the recommended schedule** | Care coordinators provide education and reminders to parents/caregivers to increase compliance with EPSDT well-child visits with referrals to and follow-up with specialists for any concerns about developmental milestones. |
| **Percent of early warning indicators, including screening positive for adverse childhood experiences, sleep problems, and developmental anomalies** | Care coordinators screen for and address adverse childhood experiences, anomalies in growth/development, sleep problems, and social emotional disorders. |
| **Percent of at-risk youth connected to evidence-based SUD services** | Based on screening and assessment for SUD, the care coordinator secures linkages to treatment resulting in more youth being identified and engaged in SUD care. |

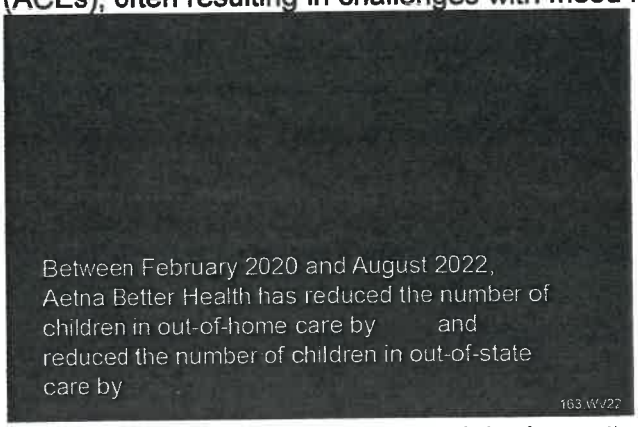
## Care Coordination services and policies

Aetna employs the CAT approach for care coordination to reduce fragmentation, with the goal of helping members experience a seamless process while obtaining specialized services available from different funding streams, programs, and plans. Our care coordinator drives our CAT model providing care coordination through convening, advocating, supporting, and connecting youth and families to resources and supports including relatives, friends, community members, and new relationships. We leverage and maximize supports and services beyond physical health and behavioral health needs; we work with the child and family to identify other areas of interest and activities that bring them joy and connect them with matching community resources to build resiliency.

Aetna commits to supporting the **members and their caregivers as the lead voice in the care planning process.** The members and their family identify individuals in their circle of support, including family members, caregivers, representatives, or other important people in their lives. The circle of support members join the care team for ongoing gathering of assessment information and development

of a single care plan. We have discussions about the services and supports they need, as well as finding opportunities for balance and incorporating joy and play.

Children and youth enrolled with Aetna may experience high rates of adverse childhood experiences (ACEs), often resulting in challenges with mood regulation, attachment, behavioral control, and other areas of diminished functioning. They are often misdiagnosed or have multiple diagnoses (at times conflicting) and are prescribed psychotropic medications when they have untreated trauma. We engage psychiatrists trained to understand the role of ACEs and trauma to evaluate and review medications and adjust accordingly as well as connect the members to trauma-informed care treatment to mitigate possible misdiagnoses and inappropriate prescribing.




Because of our focus on SDoH and the impact on health care access and quality of life, Aetna includes attention to socioeconomic status and access to housing, nutrition, education, and employment. In addition, we believe that by supporting our members in addressing their SDoH, we can help support their families with prevention of re-entry or initial entry into the foster care system. Our focus centers on providing access to care and social determinant resources, **supporting kinship care (which has been extremely successful)** whenever possible over foster care. We believe relatives are the preferred source of care for children who must be removed from their birth parents as kinship care maintains familial connections for the child. The table below outlines our recommended measures to determine if care coordination is having a meaningful impact on the health outcomes of our members. We coordinate with the Bureau for Social Services (BSS) to identify and assist in tracking the following measures relating to our care coordination efforts. Our Care Coordination teams help ensure the documentation of care coordination activities through the child's comprehensive and centralized care plan, created in collaboration with other professionals involved in treatment and the child's circle of support.

| Care Coordination Measure | Description |
|---|---|
| **Percent of care plans that include community engagement activities** | Many of these children and families live in cultural and social isolation. Connection with community and activities increases the likelihood of healthy behaviors and outcomes. Our care coordinators encourage activities the child and family might like including cultural or faith-based events. |
| **Rate of improvement in quality-of-life indicators** | In collaboration with the Harvard Lee Kum Sheung Center for Health and Happiness, Aetna has embraced that measurement of quality of life includes a combination of objective well-being measures (education, physical and built environment, community, and economy), and subjective well-being measures (psychological, social, and spiritual). Our care coordination services and policies connect members and their circle of support to both types of resources to improve health outcomes and overall quality of life. |
| **Social determinants of health (e.g., physical activity, consumption of healthy foods, pro-social activities, etc.)** | Health is measured based on environmental factors, including but not limited to increased access to healthy foods, regular exercise, time with family and friends, and the overall reduction in toxic stress. |
| **Behavioral health challenges (mental health and substance use) including crisis and inpatient stays** | The care coordinator works closely with all involved providers including mental health and substance abuse to decrease crisis and inpatient stays. |
| **Number of children placed in out of home care/residential** | The care coordinator works closely with the child, family, providers, and community resources to ensure all needs are met, resulting in decreased number of children placed outside the home. |

| Care Coordination Measure | Description |
|---|---|
| **Length of stay in out of home care and residential** | When the member requires out of home care or residential, care the care coordinator works closely with the child, family, providers, and community resources to ensure all needs are met upon discharge, resulting in reduced lengths of stay. |

## Utilization management services and policies

Our Utilization Management program coordinates care for members and families in the most appropriate setting. As directed by the chief medical officer/medical director, physical health and behavioral health medical directors provide oversight of Aetna's clinical functions including quality management, utilization management, care management, and credentialing. The medical directors provide clinical leadership for the Quality Management/Utilization Management Committee, conduct medical necessity reviews, conduct peer-to-peer reviews, and provide mentoring and clinical leadership for the integrated care management program. We have policies in place to make sure members are not denied important services for long-term safety, stability, and normal development.

All our qualified health professional staff have active licenses where required with applicable experience. Most of our staff are West Virginians with active West Virginia professional licenses. These individuals are neighbors serving neighbors as our staff are very familiar with resources/services specific to their area and allows for relationship building with providers/practitioners in the area. This local presence results in increased continuity of care and engagement for members. We assign **our care coordinators and utilization managers to cases until resolution; they conduct daily rounds to continually stay informed of the member's and families' needs.** The table below outlines our recommended measures to determine if utilization management is having a meaningful impact on the health outcomes of members.

| Recommended Utilization Management Measure | Description |
|---|---|
| **Rate of inappropriate denials/overturn on appeals** | Aetna recognizes that the care team and circle of support promote what is best for the members and family. Aetna collaborates with the care team and communicate directly with providers, including peer-to-peer discussions. |
| **Percent compliance with authorization timelines** | We complete service authorization requests timely and efficiently in compliance with established NCQA turnaround timeframes and contract requirements. |
| **Rates of ED utilization, hospital readmission, length of stay, and NICU admissions** | We use nine utilization management dashboards, which provide data reports on readmissions, observations versus one-to-two-day stays, ED utilization, NICU admission patterns, outpatient urine drug testing patterns, medical claims trends, authorization trends, outpatient utilization trends, and inpatient performance targets. Through these reports, we can identify and engage high utilizers into lower levels of care. |
| **Rates of gaps in care** | We evaluate gaps in care every time we interact with a member. This allows us the opportunity to not only encourage needed care but also assist in getting the members to the visit. We share gap in care reports with our network providers and work with them to assess members' needs in closing gaps in care. |
| **Drug over- and under-utilization patterns** | We conduct retrospective drug utilization reviews to detect pharmacy over-utilization. Aetna applies these reviews to assess drug over- and under-utilization patterns to drive the development of interventions and/or educational activities. |

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## Proposed Member satisfaction measures [QU18]

Aetna assesses member and family experience through various methods, including the administration of the CAHPS survey and the Aetna Behavioral Health Member Satisfaction Survey, as well as by evaluation of member complaint and appeal information. CAHPS surveys include questions related to a range of health care services at multiple levels of the delivery system and show member satisfaction as depicted in the table below. The survey includes the member's rating of their personal doctor, specialist seen most often, all health care received, and health plan overall. Aetna has adopted the CAHPS children with chronic conditions version of the survey to help ensure CSHN and their families are receiving appropriate care and are satisfied with services. This version is specifically geared to the target population and allows us to identify trends more efficiently in member satisfaction. Complete CAHPS survey results are provided to the State annually. In addition, we hold a series of multi-disciplinary work groups to analyze and prepare an action plan to address any measures that do not meet the 25th percentile. We submit this information to the State by August 15th of each year.

| CAHPS Measure | 2022 Rate and Percentile | 2021 Rate and Percentile |
|---|---|---|
| **Getting Care Quickly Composite** | 95.55%/95th | 95.16%/95th |
| **Getting Needed Care Composite** | 91.69%/90th | 91.61%/75th |
| **How often did you get an appointment for your child to see a specialist as soon as you needed?** | 88.50%/75th | 90.0%/90th |
| **How often was it easy to get the care, tests, or treatment your child needed?** | 94.90%/95th | 93.20%/75th |
| **When you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?** | 95.1%/95th | 92.50%/90th |
| **When your child needed care right away, how often did your child get care as soon as he or she needed?** | 96.0%/90th | 97.9%/95th |

Aetna has always used CAHPS survey results to identify and investigate areas of member dissatisfaction, outline action steps to follow up on the survey findings and develop an action plan. The action plan includes implementation steps and a timeline for completion. We forward quarterly updates on the CAHPS action plan to BMS as required by the contract. Based on this analysis, the CAHPS review team reviews the key measures, drivers, and data to identify barriers, discuss opportunities for improvement, and prioritize actions. For example, **based on feedback captured via CAHPS, we identified key areas and actions for improvement such as Addressing SDoH needs to support members and address barriers to obtaining care. As a result, care managers address SDoH needs with all members enrolled in case management and educational resources were developed for both the member and provider audiences.** Educational collateral highlighting community-specific resources via WV 211 was developed and sent to over 1,500 providers and their staff. New member welcome kits, member handbooks, and member newsletters now routinely feature content specific to engaging and enhancing member awareness of social resources through FindHelp.org and WV 211. We contracted with FindHelp.org to develop a West Virginia-specific link for members to access the FindHelp site for assistance with food, bill payment, and other free or reduced cost program. Our staff also receive education on obtaining and analyzing data to understand utilization and opportunities.

## Sample Quality Profile Reports

The provider profile report to the right contains a member list of needed care or services for each indicator, so providers can address all known gaps in care when patients are in the office or for use in provider/member outreach. We continue to refine the tool, especially requesting regular feedback from providers to make it more user-friendly.

**VBS Quality Report**
**Summary**
**Plan: WV**
LOB: TANF_ACA_SSI_CHP
Time Period: YTD
Report prepared for Contract:
**VBS Provider**
Panel Size:
*as of 8/1/2022*

| Measure Name | Your Rate | | | Comparison Rate | |
|---|---|---|---|---|---|
| | Numer | Denom | Rate | Target1 | Target Meeting (Y/N) |
| Breast Cancer Screening Non MCare (BCS) | 66 | 166 | 39.29 | 53.93 | N |
| Cervical Cancer Screen (CCS) | 379 | 841 | 45.07 | 59.12 | N |
| Childhood Immunization Status Combo 10 (CISR) | 8 | 28 | 28.57 | 36.20 | N |
| Comp Diabetes: Eye Exam (CDC) | 65 | 197 | 32.99 | 51.32 | N |
| Comp Diabetes: HbA1c Adequate Control (<8) (CDC) | 18 | 197 | 9.14 | 46.83 | N |
| Controlling High Blood Pressure (CBP) | 157 | 353 | 44.48 | 65.47 | N |

*Claim Dates of Service from 1/1/2022 to 7/31/2022*
*Paid Thru 7/31/2022*

Report Definitions:
Panel size = Count of currently enrolled members assigned to a provider/provider group.
Numer (Numerator) = All members assigned during the reporting period, who were identified through claims data as having received or experienced a numerator event.
Denom (Denominator) = All members assigned during the reporting period, who satisfy specified inclusion criteria for the measure, such as age, sex , diagnosis and enrollment.*
Rate = The calculated performance rate for the selected measure.
Target= The contractually agreed upon goal performance rate for the designated metric.
**Target rates are generally set using national benchmark rates, which are based on percentiles (50th, 75th, 90th, etc.). Please review contract terms for more details.

To develop provider scorecards, Aetna leverages data analysis and performance metrics to direct activities for CQI addressing health inequities and preventive care. Data capture and analysis for the scorecards includes examples such as HEDIS performance profiles; EPSDT utilization; network adequacy reporting including out of network usage; pharmacy and medical utilization reports; prevalent condition heat mapping and SDoH needs identified at the community level; and claims. We use monthly gaps in care reports from the integrated quality management data systems to perform member outreach.

## Rationale for selecting performance measures in sample report

We select specific measures in the profile report because they relate to a high volume of the eligible population of children and youth in the foster care system and individuals receiving adoption assistance, as well as measures that are important to the State. These measures are consistent with our goal of promoting preventive care and align with the DHHR's goals. The Provider Optimization Delivery team will also pull measures from Mountain Health Promises PIPs, gap in care reports, and other key West Virginia projects.

## Proposed frequency of report distribution

Our Provider Optimization Delivery teams will generate the profile reports quarterly with our provider services representatives, meeting with these providers in their offices biannually to share the profile reports, answer questions, and mitigate issues or problems. They educate providers on Medicaid managed care, billing, prior authorization requirements, and specific issues facing their members; and verify demographic and roster information, appointment availability, and compliance with Americans with Disabilities Act and Aetna's cultural competency requirements and complies with Section 3.7.7 of the Model Purchase of Service Provider Agreement concerning timely payment requirements. Representatives will provide education on any topic pertinent to the provider and help them to understand their performance in relation to the defined measures and their standing among their peers. Our provider profiling expands beyond traditional physician-based providers and includes facilities and home- and community supports and services. We will create ad hoc profiles as needed throughout the year based on performance indicators. All providers who meet eligibility requirements for program participation will receive profile reports. We distribute reports by mail, fax, and in real-time through the provider web portal.

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### Subcontractor oversight to ensure member outcomes

| | |
|---|---|
| QU21 | The Vendor should use reports/data from subcontractor(s), as applicable, to ensure appropriate subcontractor oversight and the following member-related outcomes:<br>• Access to care<br>• Member satisfaction<br>• Continuity of care<br>• Changes in functional ability<br>• Appropriateness of vendor care plan<br>• Timeliness of care<br>• Length of stay/Level of Care<br>• Appropriate discharge planning<br>The Vendor should describe how it will meet these specifications. |
| QU20 | The Vendor should monitor and reinforce primary care provider compliance with program requirements for populations eligible for medical services. 1) The Vendor should describe how it will meet this specification, in general. 2) The Vendor should describe specifically how it will meet this specification for program requirements including, but not limited to:<br>• 24-hour coverage<br>• Appointment scheduling<br>• Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity standards |

## Oversight and monitoring of providers and subcontractors [QU21]

Aetna performs ongoing monitoring of subcontractor performance, including meeting with subcontractors weekly, monthly, or quarterly, depending on the subcontractor. We also perform a comprehensive review at least annually in which we review ongoing performance as well as measure performance efforts that address past concerns identified by the Department. If we identify any deficiencies or areas for improvement, we require the subcontractor to take corrective action. If requested, Aetna provides the DHHR with a copy of the annual review and any corrective action plans developed as a result.

**National oversight:** At the national level, we have a centralized team of delegation oversight experts that manage the oversight process across the Aetna organization to make certain that all our multi-state delegated agreements are represented and that all requirements, such as State- and contract-required elements for each plan and delegate, are accounted for.

### Subcontractor monitoring and oversight activities

**Subcontractor Monitoring includes:**

- **Monitoring and evaluating** delegated functions through at least semiannual reports
- **Conducting pre-assessments prior to delegation**, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- **Confirming (no less than annually) that delegated functions/services are carried out consistently** and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed upon delegation agreement
- **Performing, at minimum, an annual file review audit**, if applicable, to confirm compliance with Aetna and applicable standards
- **Monitoring ongoing corrective actions** to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- **Reviewing the delegated organization's program** that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes

- **Monitoring the subcontractor downstream provider agreements** to ensure they comply with the regulatory requirements of the Model Purchase of Service Provider Agreement

**Local oversight:** The Quality Management Oversight Committee has the ultimate authority and responsibility to validate that we meet monitoring requirements. The committee meets six times per year and reports to senior leadership.

Team members from the network management, provider services, operations, and quality management departments receive training to report subcontractor-related concerns to management. For example, our care coordinators are often the front line in identifying potential problems or issues related to vendors and subcontractors. If an interaction with a member related to a subcontractor raises a red flag, the care coordinator will escalate the issue to management. Issues can often be resolved without further escalation once referred to the appropriate department for remediation.

**Delegation oversight activities are formally monitored as a component of the QAPI program. We submit audit reports of delegated activities and corrective action plans, if applicable, to the appropriate oversight committee (e.g., Quality Management/Utilization Management and Delegation Oversight Committees) for review and approval and then send to the Quality Management Oversight Committee.** Should deficiencies be identified, Aetna works with the delegated organization to set priorities and develop a corrective action plan. We retain the right to revoke the delegation agreement for noncompliance or if corrective action plans are not sustained.

### Using data from subcontracts to ensure appropriate oversight

Although we may delegate the authority to perform functions in support of the West Virginia Medicaid managed care program, we do not delegate accountability for the quality of care or services the subcontractor provides. Our QAPI program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function.

Our local Delegation Oversight Committee requires all subcontractors to report various measures to the committee to ensure comprehensive oversight. **The following includes data sources used to monitor subcontractor performance and ensure that they are meeting all contractual responsibilities as they provide service to our members:**

- **Customer service call data**: We track data from each subcontractor monthly to ensure that members have access for customer service needs.
- **Claims data**: We report monthly data on claims payment timeliness and accuracy to the Delegated Oversight Committee quarterly.
- **Network adequacy**: We report network adequacy at least quarterly to the local Delegation Oversight Committee. This includes reporting on requests for out-of-network services, which is a key indicator of the subcontractor's ability to adequately provide needed services.
- **Provider appointment surveys**: Reported at least annually by each subcontractor, as applicable
- **Utilization management reviews, including clinical reviews, prior authorization, and retroactive authorization reviews**: We report monthly data on a quarterly basis to the local Delegation Oversight Committee by each subcontractor to monitor utilization practice patterns.

In addition to the monthly/quarterly monitoring noted above, our national Delegation Management team conducts an annual oversight audit of each subcontractor to evaluate subcontractors' compliance with standards and criteria. These audits include review of associated policies and procedures and file audits, where applicable. The local Delegation Oversight Committee reviews the audit tools to help

ensure the inclusion of local contract-required service-level and metric requirements. If audit results reveal an issue with the vendor's compliance with the service level agreement, the frequency of our monitoring activities increase accordingly.

### Using subcontractor data to monitor outcomes related to access to care

Aetna monitors subcontractors' accessibility and availability on an ongoing basis to help ensure established standards for reasonable geographical location, ratio of subcontractors to members, hours of operation, appointment availability, and coverage for emergency care and after-hours services. To monitor subcontract outcomes related to access to care, we use encounter data submitted by our vendors on a weekly and monthly basis. There is also an annual GeoAccess review performed and reviewed to help ensure that our vendors meet the access to care standards. We review the data collected during regular Joint Operation Committee meetings. We discuss subcontractors identified as not meeting the standards, and we work with the subcontractor to get the necessary actions required implemented to meet access to care requirements. Given our well-established relationship with our vendors, access to care standards have always been met and exceeded. If access to care issues arise, it would result in contract remediation up to contract termination.

### Using subcontractor data to monitor outcomes related to member satisfaction

We require all subcontractors to send member complaints to Aetna for resolution. We bring increases and trends in complaints to the Service Improvement Committee for discussion and possible corrective action. Aetna reviews and captures this information for children and youth in the foster care system and individuals receiving adoption assistance.

### Using subcontractor data to monitor outcomes related to continuity of care

Aetna recognizes the importance of maintaining continuity of care and service whenever a member's care setting or practitioner/provider changes. Aetna integrates processes to guard against interruptions in care. We track issues related to continuity of care with our subcontractors through out-of-network referrals in weekly reports to ensure our members have access to the services they need; we create single case agreements as needed. In addition, we receive approved and denied authorizations, which are then reviewed by the prior authorization staff for appropriateness. Quarterly, the Delegated Oversight Committee reviews out-of-network referrals for continuity of care and transitions of care and related concerns, and if issues are identified, the subcontract may be put on a corrective action plan. We address issues identified affecting the continuity of care for our dental subcontractors through an action plan implemented at that time. We address other data, such as changes in functional ability; appropriateness of vendor care plan; timeliness of care; length of stay/level of care; and appropriate discharge planning internally at the local health plan level, and we do not use any outside vendors for these assessments.

### Taking action against providers demonstrating unacceptable performance

The Quality Management and Provider Services staff work together to monitor network practitioner and provider performance, including SNS providers. Quality Management staff assists Provider Services staff to develop measurable objectives to evaluate provider performance; analyze data collected in the monitoring process; and prepare information for the Quality Management Oversight Committee. If the reported data indicate the need for an action plan or additional studies, quality management assists in developing tools and reporting results and outcomes to the Quality Management Oversight Committee and to the DHHR, as appropriate. The Aetna Quality Oversight Committee conducts peer review and investigates quality of care or service, and member safety issues, makes recommendations to the chief medical officer/medical director, and requests follow-up by the Aetna Credentialing and Performance

Committee, if appropriate. The Aetna Credentialing and Performance Committee conducts professional review activities involving the practitioners whose professional competence or conduct adversely affects or could adversely affect the health or welfare of members. The range of actions available to the Quality Oversight Committee and/or the Credentialing and Performance Committee includes practitioner education, requirement of a corrective action plan, or termination of the practitioner contract. Actions taken by the Quality Oversight Committee or the Credentialing and Performance Committee are reported to Quality Management Oversight Committee and the DHHR, as appropriate.

Kepro authorizes SNS according to the SNS Utilization Management guidelines. After the prior authorization of the service, the SNS provider conducts the service for the member. On an 18-month cycle, Kepro conducts consultative reviews of all enrolled providers who have been active during the specified review period.

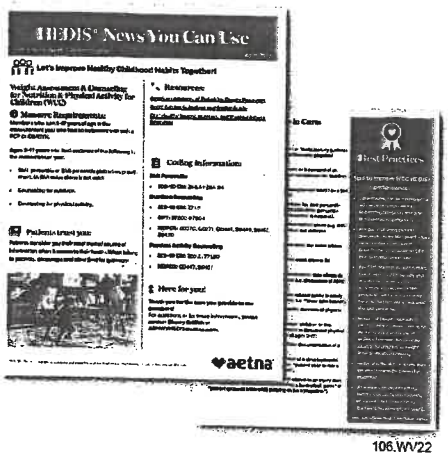
### Sharing best practice methods and programs

For providers participating in our APM programming, we employ a multi-faceted approach to share best practices on an ongoing basis. **We share and communicate best practice methods and programs with our providers through a variety of forums**, including but not limited to the following:

- **Face-to-face visits** by members of the Provider Relations and Quality Management teams
- **Provider collaborative** for trauma-informed care
- **Bulletin updates** via fax blasts
- **APM teams working directly with providers** on practice incentives based on evidence-based practices and outcomes
- **Co-location in facilities**; working with providers on education directly
- **Guest lectures** at association meetings
- **Dental letters for opioid prescribing** (we reviewed prescribing patterns and identified outliers and sent them letters with information on best prescribing practices)
- **Peer-to-peer calls**

Aetna shares best practice methods and coordination with the DHHR through a direct relationship and includes the DHHR in key roles with the training collaborative. Participation by DHHR representatives in the core model training provides direct and frequent interaction between members, providers, and DHHR staff partners, ensuring opportunities for direct insight into the impact of Aetna implementation and operation.

### Best practices shared with our provider network



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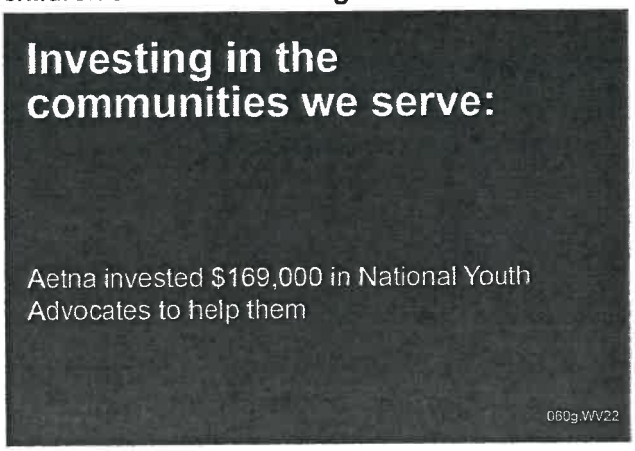
Examples of best practices shared with our provider network include our neonatal abstinence syndrome program, flu vaccinations, diabetic dental practices, and diabetic-asthma project with community health workers. We share best practices with our provider network by working directly with the provider offices. We prioritize building provider relations through one-on-one education, web-based, on-demand trainings including offering continuing education credits, provider support in resolving problems, and supporting timely provider communications via our provider portal, network notifications, and one-on-one interactions with our provider support teams

## Best practice methods/programs for consideration with SNS providers

Collaborative relationships are at the center of Aetna's approach to serving the West Virginia children's population. Aetna selected a nationally award-winning model called Collaborative Family Engagement as a framework and methodology to strengthen and sustain a partnership with the BSS staff and leadership. Collaborative Family Engagement is one of the first in the nation to approach building a collaborative effort to bring a health system and child welfare system together to support and strengthen the safety of children and the well-being of families. This unique approach allows us to stand shoulder-to-shoulder with the child protection system supporting and strengthening the safety of children and the well-being of families.




Aetna uses a CAT approach that provides evidence-based, trauma-informed care treatment and recovery services. Aetna has learned that many child and adolescent members have had trauma in their lives and are best served to receive all aspects of their care from a trauma-informed perspective, including from Aetna staff and our provider network. We understand that trauma is often a part of our members' history and has incorporated a trauma-informed system of care into our integrated care delivery model. We know that adult outcomes associated with ACEs include increased risk for heart disease, diabetes, obesity, cancer, intimate partner violence, depression, smoking, substance abuse, and early death. Aetna's CAT includes trauma-informed care trained care coordinators and a network of providers that includes providers providing trauma-informed care services. Where there are gaps in the network, Aetna provides training for providers to ensure at-risk youth have access to trauma-informed care services.

Our interdisciplinary care coordinators, who are part of Care Coordination teams, act as a resource for both members and all participants of the West Virginia child welfare system of care, including community organizations, family support, and foster care providers. This step helps to coordinate collaborative services and promotes access and continuity of care. Our local and community-based team has a knowledgeable team of social workers, registered nurses, and counselors who have a wide variety of expertise, including experience caring for youth (sometimes with lived experience); they are fully trained to assess a comprehensive profile of each member. We ensure that our care coordinators understand the impact of ACEs and the importance of creating an environment of safety that does not cause re-traumatization. We apply trauma-informed care standards, and our training emphasizes the roles and responsibilities of the DHHR and other children's services agencies and those of foster parents in making decisions on behalf of children in foster care.

## Monitoring and reinforcing Primary Care Provider Compliance [QU20]

Aetna's commitment to serving as a good steward of West Virginia resources is demonstrated by our monitoring and oversight processes, including daily departmental operational meetings, daily cross-function operational oversight meetings at the executive leadership level, provider and network escalation processes, and primary care provider oversight processes. **Aetna conducts the following monitoring activities related to primary care providers:**

- Accessibility analysis
- Availability analysis
- Medical record reviews
- Readmission rates
- ED utilization
- Inpatient utilization
- Pharmacy spend
- Medical cost

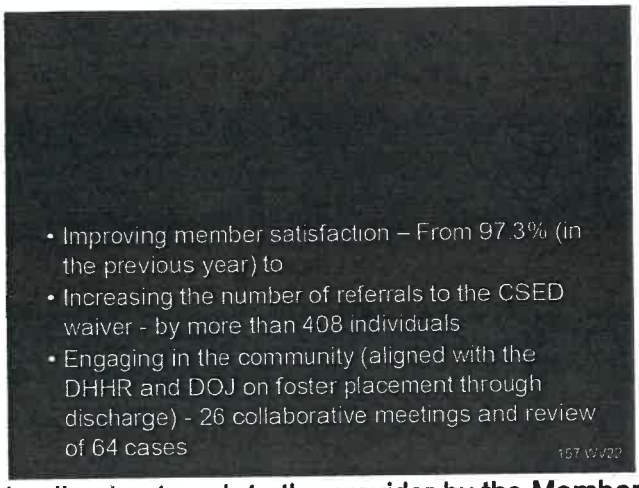
In 2021, the practitioner appointment accessibility fax survey results revealed that over 90% of practitioners in the specialties of general/ family medicine, internal medicine pediatrics and nurse practitioners met the appointment accessibility standard for regular/ routine care as well as urgent care appointments. It is also noted that 100% of practitioners evaluated in this fax survey met the requirements for after-hours accessibility. As part of the initial credentialing process in 2021, Provider Relations representatives conducted five primary care practice site visits. These site visits included a review of the practitioner's appointment schedule to evaluate appointment accessibility and to determine if the health plan's appointment accessibility standards were being met. All these practitioners met or exceeded the appointment accessibility standards.

### Monitoring and reinforcing 24-hour coverage

We currently monitor and reinforce 24-hour coverage for the primary care provider through our internal quality management process. Prior to contracting, primary care providers must include information on their credentialing application outlining how they meet this requirement. In addition, we review this requirement again during the initial onsite credentialing visit. The annual accessibility survey also includes questions regarding 24-hour coverage and how they are meeting this requirement. If Aetna determines a primary care provider is noncompliant with the 24-hour coverage requirement at initial application, then the primary care provider is not permitted to join our network. We provide education to primary care providers on the requirements if deficiencies are noted at any time throughout the monitoring process. If we note a deficiency, the provider has 60 days to address it; if they are unable to meet the requirement, we report the provider deficiency to the Service Improvement Committee for review and possible termination of contract.

### Monitoring and reinforcing appointment scheduling

Our process for monitoring and reinforcing appointment scheduling for primary care providers is like that of the 24-hour coverage requirement. At the time of initial application, we verify the potential provider meets the contract standard of timeliness and availability of appointments. We monitor ongoing compliance with this standard via our annual provider survey; if we note deficiencies related to appointment scheduling, we meet with the provider educate them on the requirements. Providers then have 60 days to address the deficiency. If the provider still fails to comply with the requirement, the

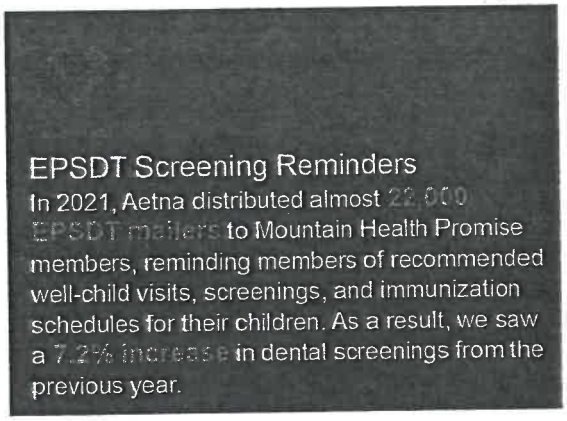



Quality Management / Utilization Management Committee reviews and determines additional corrective actions that may be warranted, including potentially terminating the provider's contract. In addition to the annual appointment availability analysis, we also monitor our complaint and grievance data to identify potential concerns with appointment accessibility. Our Complaint Committee reviews every member complaint to ensure satisfactory resolution of the issue with the member/caregiver/guardian. Any complaints regarding appointment scheduling would be handled by direct outreach to the provider by the Member Services team. In any situations where there would be a trend in member complaints (defined as three or more complaints) regarding appointment accessibility, the provider relations representative reaches out to the provider to address the issue.

## Monitoring and reinforcing EPSDT periodicity standards

We believe early detection, screening, and interventions are essential to identifying developmental, physical, and behavioral issues. We recognize that primary care providers are central to the identification of possible developmental delays in young children as part of the EPSDT program. We offer families a choice of providers who conduct ongoing developmental surveillance in accordance with medical necessity criteria specific to EPSDT.

To make sure all eligible members have access to the West Virginia HealthCheck EPSDT program, we provide a combination of written and oral notification methods designed to effectively inform all EPSDT-eligible individuals, their families, and their foster care parents and child protective service (CPS) worker, if applicable, about the EPSDT program. We will continue to provide appointment reminders, follow-ups, and outreach to EPSDT-eligible members, including targeted education and post card reminders for needed screenings.




Aetna care managers also educate members 21 years and under on EPSDT during outreach calls. If we identify a gap of care through our documentation system, we address it on a call with the member or guardian. We cover all EPSDT services. If a service not currently covered by Aetna is considered EPSDT, we make an exception and pay for the service. We do not require prior authorization for covered periodic screenings and immunizations.

We work closely with providers to make sure all Medicaid-eligible members under the age of 21 receive EPSDT services and their parents, caregivers, and providers use resources effectively. Aetna routinely monitors for gaps in care using our care management and utilization management systems. We provide EPSDT coverage that aligns with guidelines outlined in the Service Provider Agreement including providing an initial health assessment and comprehensive exam within 30 calendar days of placement in foster care. If necessary, we also provide a follow-up visit within 90 calendar days of placement in foster care. Once

the child is enrolled with us, we work with the assigned BSS worker to make sure the timely performance of these important health assessments, exams, and follow-up visits.

Aetna monitors and reinforces EPSDT screening and well-visit rates monthly and quarterly. Regular monitoring helps us to identify strategies that are working well and provides insights into areas where we may be able to overcome members' barriers to care. Aetna Care Coordination teams review gaps in care and set task reminders for follow-up visits for the following: children aged five and under with no screening; targeting children and youth with special health care needs with delinquent screenings; and conducting outreach to parents and caregivers of members ages 0 to 20 with delinquent well-visit exams or screenings on the importance of well-visit exams, screenings, and following EPSDT schedules.




We track EPSDT requirements and related HEDIS measures, and we use the data to generate reports and identify any early deficiencies. Some tools used include care alerts (which identify high- and medium-risk members who are delinquent), priority lists, quarterly measures and feedback, EPSDT practice profile, tracking phone calls conducted (automated and direct), and face-to-face contacts. We share the pediatric measures with the network and practices quarterly for quality improvement purposes. Additionally, **we participate in the WV Affinity Group which focuses on improving children's EPSDT compliance.** Originally directed solely at foster care populations, this group now includes representatives from all state MCOs. State teams come together for monthly group workshop calls. Workshops, delivered by webinar, are designed to introduce the use of quality improvement tools, engage states with quality improvement advisors, share states' successes and key challenges, and help teams learn from one another.

## 8. Value-Added Services

In addition to the above subject matter areas from Appendix 1: Detailed Specifications, the Vendor should include any Value-Added Services to be offered in this section, as well as any eligibility requirements and potential limits for these services. Vendors are not required to propose value-added benefits, but inclusion of such services may impact the Vendor's overall evaluation. The Vendor's narrative response should not exceed 5 pages.

Aetna Better Health® of West Virginia (Aetna) designed our suite of innovative Value-Added Services (VAS) to support State of West Virginia, Department of Health and Human Resources (DHHR) goals, deliver on our commitment to provide an optimal member experience, and support a person-centered approach to the delivery of coordinated, integrated care. Our experience serving Mountain Health Promise members provides the insight to customize VAS to support the Bureau of Medical Services (BMS) goals of **tailoring services to meet the needs of all enrolled populations and providing members with the opportunity and incentives to maintain and improve their health.** For example, based on an analysis of utilization data and review of member and stakeholder feedback, we're doubling the annual limit of our **After School Engagement** VAS to $100 to improve member participation, adding a new **Diaper Club** benefit that provides free diapers every month to families with children ages 2.5 years and under, and **increasing incentives** to improve member engagement and health outcomes.

As children and youth currently or formerly involved with child welfare agencies or diagnosed with serious emotional disorders face extra challenges accessing and engaging in their health care, we created VAS specifically to address those barriers and spark interest in using their covered benefits. Our VAS are also designed to improve member satisfaction – on the Rating of a Health Plan Composite Score of the Consumer Assessment of Healthcare Providers and Systems Child survey, our VAS contributed to our **95% score in 2022,** up from 93% in 2021.

We address individualized member- and family-centric needs through the following categories of VAS:

- **Access & Engagement:** Ensuring members and their families receive all the necessary opportunities and incentives available to support healthy outcomes, reunification, and permanency
- **Education & Training:** Promoting individual and family health, self-sufficiency, recovery, and resiliency
- **Well-Being:** Improving the well-being and quality of life for our members and their families with services, supplies, and resources that address their personalized social and health needs

Aetna commits to providing all the VAS proposed in this response (refer to table below) for the entire term of the new contract and for any extensions, if applicable.

**Summary of Aetna's Value-Added Services**

| Access and Engagement | Education and Training | Well-Being |
|---|---|---|
| • Aetna Better Care Healthy Rewards<br>• Home-Delivered Family Meals<br>• Moms and Babies Program<br>• Ted E. Bear, M.D. Cub Club<br>• Connected Care with Pyx Health<br>• Asthma Care Program | • High School Graduation Prep & Job Skills Training<br>• Afterschool Programs<br>• Connections for Life<br>• Legal Services, Clinics, and Education | • Diaper Club<br>• Calming Comfort Collection<br>• Caring Closets<br>• Keep Kids Safe: Rx Lockbox<br>• Birthday in a Box<br>• Essential Needs Duffle Bags |

The tables below provide the description, eligibility criteria, and limits and restrictions of each VAS, along with key highlights of their value.

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**Aetna's Access & Engagement Value-Added Services**

| Description, Eligibility Criteria, Limits and Restrictions, Outcomes |
|---|
| **Aetna Better Care® Healthy Rewards** |
| We'll continue to offer our Aetna Better Care® program, encouraging members to proactively maintain and improve their health. We offer all incentives to members statewide, which are available once the member completes the applicable healthy activity listed below. Since launching, we've provided **over $51,000 in rewards** to drive healthy engagement. |
| **Adolescent Immunization:** Members ages 12-18 receive a $25 reward for completing required immunizations (limit one per year); Targeting improvements in Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA). |
| **Behavioral Health Follow-up:** All members receive a $25 reward for attending a follow-up appointment after a behavioral health hospital visit within seven days (limit one per year); Targeting improvements in our Follow-up with Mental Health Provider within 7 and 30 days after Hospitalization (FUH) and Follow-Up after Hospitalization for Mental Illness (FUM) measures. |
| **Child Dental Check-up:** Members ages 2-3 can receive a $25 reward for attending a dental check-up (limit one per year). |
| Promise Delivered — This incentive helped drive a MY2021 rate for Annual Dental Visits (2-3 years old) of 44.10%, which exceeds that national average by 22.4%, and is at the 75th percentile nationally. |
| **Diabetic Eye Exam:** $25 reward when members 18+ receive a diabetic eye exam (limit one per year); Targeting improvements in our Eye Exam for Patients with Diabetes (EED) measure. |
| **HgA1c Test:** $25 reward when members 18+ complete an HgA1c test (limit one per year); Targeting improvements in our Hemoglobin A1c Control for Patients with Diabetes (HBD) measure. |
| **Postpartum Visit:** New mothers can now earn $50 after completion of one postpartum appointment within 7 to 84 days after giving birth (limit one incentive per pregnancy) |
| Promise Delivered — This incentive helped our postpartum care (PPC) rate increase 17.1% from MY2020 to MY2021. |
| **Well Child Exams**: Members ages 3-21 can receive a $25 reward for attending their annual well child exam (limit one per year); Targeting improvements in our Child and Adolescent Well-care Visits (W30, WCV) measures. |
| **Wellness Event:** $25 reward for any member participating in an Aetna wellness event (limit one per year); Targeting improvements in our Child and Adolescent Well-care Visits (W30, WCV) measures. |
| **Home-Delivered Family Meals** |
| Preparing nutritious meals that children and youth in a new placement will enjoy can be a burden on foster and kinship families in the early days of a new placement. This new VAS will help by providing home-delivered meals to newly placed members and their families, and to biological families of recently removed members. This will provide an opportunity for both children and youth and their new placement families to focus on getting to know each other, reduce burden for cooking and stress related to mealtime, and help the family learn the child's food preferences by offering a variety of meal types. It will provide some relief to biological families of removed children during a difficult time.<br>**Eligibility and Limits:** Members and their families after a new placement. Foster and kinship families can receive 14 meals; biological families can receive 7 meals.<br>**Targeted Outcomes:** Improved member and family satisfaction; improved stability and success for newly placed members |
| **Moms and Babies Program Reward** |
| New mothers can receive a cribette or baby wrap carrier upon delivery and an educational toy on baby's first birthday for enrolling in the Moms and Babies care management program.<br>**Eligibility and Limits:** Any pregnant members at 37 weeks or more; pregnant members statewide experiencing substance use and new mothers with babies born with neonatal abstinence syndrome. The program provides one cribette or baby wrap and one educational toy per pregnancy.<br>**Targeted Outcomes:** Improved member engagement with care management; improved member satisfaction |
| **Ted E. Bear, M.D.℠ Cub Club** |
| Our children's club promotes healthy habits and will continue to be a staple of our children's health strategy. Each quarter, enrolled members are encouraged to complete a health activity challenge to improve their overall health and hygiene, such as teeth brushing, exercise, etc. Once completed, members receive a reward such as a brushing kit, sports ball, etc.<br>**Eligibility and Limits:** Members statewide 13 years of age and under. Limit one reward per quarter.<br>**Targeted Outcomes:** Improved member satisfaction; increased take up and completion of healthy activities |

### Connected Care with Pyx Health

We'll offer this innovative platform as a new VAS focused on helping members who are experiencing loneliness and social isolation. Pyx Health provides 24/7 digital companionship and support intervention via a mobile platform to address member needs. Members will also have direct access to the Pyx Health compassionate support center, staffed with individuals who are trained to support members one-on-one when they screen as lonely, depressed, anxious, or indicate any social need. Examples of achieved outcomes from six Aetna markets (5,750 total members), based on analysis conducted by Pyx Health through 2022 include: **48% loneliness reduction; 62% depression and anxiety reduction; 88% of members felt connected to their health plan; 92% member satisfaction rating**
**Eligibility and Limits:** Members ages 18+ and members age 13+ who are in a kinship placement, adopted, or in the Children with Serious Emotional Disorders (CSED) waiver program with parent/guardian permission
**Targeted Outcomes:** Reduced member loneliness, depression, and anxiety; improved loneliness scores; increased member satisfaction; improved member engagement

### Asthma Care Program

To support our care management for members with asthma, we'll continue to offer one-on-one education with an asthma coach and a peak flow meter.
**Eligibility and Limits:** Members statewide with an asthma diagnosis. One peak flow meter per member.
**Targeted Outcomes:** Increased care plan adherence; reduction in asthma-related emergency room visits

## Aetna's Education & Training Value-Added Services

Description, Eligibility Criteria, Limits and Restrictions, Outcomes

### High School Graduation Prep & Job Skills Training

We'll continue to provide an online General Educational Development (GED) preparation course and certification services at no cost to the member. We also aid in scheduling the GED exam and provide a voucher to pay for the exam. In addition, members have free access to 100+ learning plans in a variety of career fields including health care, business, and more.
**Eligibility and Limits:** Members statewide who are ages 16+. Members under 18 require guardian consent, need permission from their school district, and cannot be registered in another school program.
**Targeted Outcomes:** Increased GED completions; annual increase in number of completed learning plans and certifications; annual increase in number of new jobs or promotions; improved member satisfaction

### Afterschool Programs

Participation in afterschool programs boosts academic performance, promotes physical health, and provides a safe, structured environment for the children of working parents. Qualifying members can now receive up to $100 per year to apply to costs associated with joining a participating afterschool program of their choice. While only 20 members have used the benefit since launching, with the $100 limit increase and the slowing pandemic, we expect utilization to grow significantly.
**Eligibility and Limits:** Members statewide ages 5 to 18 who are enrolled in school. Parents or custodial/legal guardians are required to give consent. Limited to $100 per year.
**Targeted Outcomes:** Increased member satisfaction; increased academic engagement and success; improved physical fitness to encourage healthy weight management

### Connections for Life®

To help address the significant technological disparities faced by youth in the child welfare system, we're proud to continue to offer this innovative VAS statewide. Eligible members receive a free tablet or laptop, education and training around technology literacy, and help connecting to key local and national resources through a proprietary member portal. The portal is a one-stop online assistive aid, providing access to hundreds of helpful free and discounted products and services.
**Eligibility and Limits:** Tablets – foster care members statewide ages 13 to 17 not placed in a pre-adoptive or adoptive home; Laptops – foster care members statewide 18 years of age and older. One laptop or tablet per member.
**Targeted Outcomes:** Improved portal access; increased frequency of member connections with their support network; improved digital access and literacy; improved member satisfaction

**Helping Jonny* Turn Around His Grades with Connections for Life®**

Lacking resources to engage in homework during the pandemic, Jonny's grades were poor. After receiving a tablet through Connections for Life, his grades improved dramatically. His foster parents said, "This device changed his grades and may have changed the trajectory of his life. If he had not received the device he may not have returned this year to graduate high school."

*Name changed to protect privacy

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| Description, Eligibility Criteria, Limits and Restrictions, Outcomes | |
|---|---|
| Promise Delivered | Since launching, **573 devices have been delivered** to our Mountain Health Promise members. For these members, **100% found the device to be useful**; 88% used the device for school, 60% to communicate with friends, family, and support network, 55% to find/access resources (including employment), and 25% have used it for telehealth. |

**Legal Services, Clinics, and Education**

The lack of access to timely and tailored legal assistance is a significant barrier for foster children and their families and perpetuates a cycle of disparity. Our members will continue to have access to a **dedicated attorney and paralegal through Legal Aid of West Virginia, which provides civil legal services to help stabilize the lives of our members.**
Eligibility and Limits: All members statewide and their biological family members. Covers legal representation in adoption, guardianship, or custody proceedings; family law; domestic violence protective order cases; evictions; poor housing cases; expungement cases; help reinstating a driver's license; Social Security disability or Supplemental Security Income terminations or reductions; food stamps, Medicaid, Government benefits cases; Individualized Education program cases; power of attorney issues; and bankruptcy.
Targeted Outcomes: Increased access to legal services; improved member satisfaction

| | |
|---|---|
| Promise Delivered | Since launching for our West Virginia members, this program has seen over 200 referrals to Legal Aid of West Virginia and held 11 educational and outreach clinics. |

**Aetna's Well-Being Value-Added Services**

| Description, Eligibility Criteria, Limits and Restrictions, Outcomes |
|---|

**Diaper Club**

We recognize that access to clean and dry diapers are essential to a baby's healthy development but can also present a significant financial burden for parents. To support parents in putting their baby's health first, we're excited to offer this new VAS that provides up to $45 for diapers per month to members with young children.
**Eligibility and Limits:** Members 0-2.5 years in age. Up to $45 in diapers per month per dependent child.
**Targeted Outcomes**: Increased member satisfaction; increased member engagement

**Calming Comfort Collection**

In line with our trauma-informed care focus, we're introducing a new VAS that provides members the option to order supplies to help calm the impact of trauma. Items include a sound machine, aromatherapy, light therapy products, and weighted pillows/blankets.
**Eligibility and Limits:** Members with anxiety or an Adverse Childhood Experiences (ACEs) score of 2 or higher; up to $50 in approved supplies/year.
**Targeted Outcomes:** Increased member satisfaction; member assessment of impact of supplies

**Caring Closets**

Listening to our members, we know the personal and social challenges that foster youth face due to not having or being able to afford clothing to fit their lifestyle and personality. This new VAS will provide our newly displaced members with a $100 clothing fund twice per year to build a wardrobe that suits them while also providing an opportunity to spend quality time with their new family while shopping.
**Eligibility and Limits**: Newly displaced youth, ages 13+ can receive two $100 deposits on a reloadable card each year.
**Targeted Outcomes**: Increased member satisfaction; increased member engagement; increased member self-esteem

**Keep Kids Safe: Rx Lockbox**

With **over 680 lockboxes** delivered to Mountain Health Promise members, we're excited to continue offering this harm reduction intervention that supports safety by providing legal or custodial guardians with a lockbox to secure their medications.
**Eligibility and Limits**: Legal or custodial guardians of members statewide who are prescribed a narcotic and have children in their home. One lockbox per household.
**Targeted Outcomes**: Decrease in children's inpatient admissions due to accidental exposure to prescription drugs

**Birthday in a Box**

Members can continue to receive a gift box on their birthday that includes an age-appropriate educational toy, party decorations, and other items to make sure the member has a happy birthday.
**Eligibility and Limits**: Members statewide categorized as medically complex. One birthday box per member per year.
**Targeted Outcomes**: Increased member satisfaction; increased member engagement with care management

**Essential Needs Duffle Bags**

We'll continue to provide duffle bags with essential hygiene and other personal care supplies to support our members in the child welfare system. Bags include a blanket, toothbrush, toothpaste, a hairbrush, and we include items such as body wash, shampoo, and conditioner based on member needs. We've provided over 250 bags since launching.
**Eligibility and Limits:** Members statewide who are newly entering the child welfare system or who aren't placed in a pre-adoptive or adoptive home. Limited to one duffle bag per member.
**Targeted Outcomes:** Increased member satisfaction and stability and success during new placements and transitions

## Driving Value with Technology, Engagement, and Continuous Improvement

To optimize use and impact of VAS, we'll leverage our proprietary **Health Innovation Platform™** to centralize, monitor, and evaluate a comprehensive array of VAS metrics (e.g., engagement, effectiveness, utilization, clinical outcomes, and spend). Data in the platform is integrated with the member portal and app and helps members understand which VAS they're eligible for and details on each—offering the member suggestions and notifications for additional VAS that may meet their needs. Members can also view their available balances and request additional information from the member app and web portal.

In addition to these member-facing uses, the platform also supports our member services representatives and care coordination managers, who can leverage it to proactively identify and suggest VAS that are appropriate to a member's needs and relevant to their individual priorities.

# Department of Health and Human Resources

## ATTACHMENT F: SAMPLE CASE SCENARIO

Instructions: A sample case scenario is described below. The Vendor should explain how it would care for the child using the question-and-response format provided beneath the scenario. The Vendor's response to Attachment F should not exceed 30 pages.

## Case Scenarios

### 1. MEMBER A CASE SCENARIO

Member A is an 11-year-old MHP member with a diagnosis of autism and intermittent explosive disorder and is physically aggressive toward others. Member A is currently in a residential mental health treatment facility in West Virginia. During an outing, Member A gets angry, becomes aggressive, and physically assaults a staff person, causing injury. Member A is taken to a Bureau for Juvenile Services (BJS) facility until a treatment facility that can meet the member's needs can be located.

**Questions:**

1) How will the Vendor monitor residential and foster care placement disruptions that result in a child being placed temporarily in a non-foster care placement?
2) Please describe the Vendor's communication protocol with the DHHR caseworker and other relevant case personnel in this scenario.
3) After the Vendor receives notification about the placement in BJS, how will the Vendor assist the caseworker in assessing Member A for appropriate services and identifying and securing additional treatment options and supports designed to meet the youth's needs to transition them from inappropriate, non-foster-care placements?

### 2. MEMBER B CASE SCENARIO

Member B is 14 years old and has an Intellectual/Developmental Disability (I/DD) diagnosis. Member B is taken to a BJS facility in the middle of the night after being charged with domestic battery for physically assaulting their mother, causing injury. Member B is removed from the home, placed in the custody of BSS, and enrolled in MHP. The Department is court ordered to obtain a forensic competency evaluation of Member B. The Vendor will use the evaluation to recommend services in the least restrictive setting that serves the needs of Member B.

**Questions:**

1) What steps will the Vendor take to coordinate the assessment of the child's ability to remain safely in their home and ensure intensive supportive community services?
2) Since the member may be eligible for the waiver, how will the Vendor coordinate assisting the child's caregiver and caseworker in applying for the waiver on behalf of the child?
3) How will the Vendor assist the caseworker in identifying and securing additional behavioral health services to obtain the needed forensic evaluations when the youth has not previously been in foster care?

4) How will the Vendor assist the caseworker in identifying and securing any required services as recommended by the forensic evaluation, which may include treatment services, educational services, and/or medications?

### 3. MEMBER C CASE SCENARIO

Member C is a 16-year-old male residing with his aunt as a kinship foster placement. Member C has been charged with a delinquency battery petition in juvenile court after an argument with his aunt escalated to physical violence. Neither the aunt nor juvenile were seriously injured. The juvenile's aunt is requesting the child be removed from the home and placed in another placement.

**Questions:**

1) How will the Vendor assist the caseworker in demonstrating to the youth's aunt the ability of intensive in-home supports to serve the family as an alternative to residential treatment?
2) How will the Vendor support the caseworker in identifying and accessing services for the family, including coordinating immediate crisis and supportive services and necessary assessments and evaluations to determine the ongoing service needs? How will the Vendor assure the family receives needed services identified through assessments and evaluations timely to prevent removal of the child from the home?
3) If the child is unable to remain in the home in this scenario, what steps will the Vendor take to ensure the ongoing treatment, assessment, and discharge planning includes the services necessary to transition the child back into their kinship home?

## Case Scenarios Response

1. MEMBER A RESPONSE

2. MEMBER B RESPONSE

3. MEMBER C RESPONSE

# Attachment F: Member Case Scenario A

**1. Member A Case Scenario**

**Member A is an 11-year-old MHP member with a diagnosis of autism and intermittent explosive disorder and is physically aggressive toward others. Member A is currently in a residential mental health treatment facility in West Virginia. During an outing, Member A gets angry, becomes aggressive, and physically assaults a staff person, causing injury. Member A is taken to a Bureau for Juvenile Services (BJS) facility until a treatment facility that can meet the member's needs can be located.**

## 1. Supporting Michael to avoid future placement disruptions

1. **How will the Vendor monitor residential and foster care placement disruptions that result in a child being placed temporarily in a non-foster care placement?**

Michael requires monitoring of his recent placement disruption and subsequent placement in the Bureau of Juvenile Services (BJS). The Bureau of Social Services (BSS) caseworker and the care team members work urgently to coordinate appropriate services, treatment options, and develop a support network designed to meet Michael's individualized, whole-person needs. See Figure F.A-1 for a summary of Michael's case.

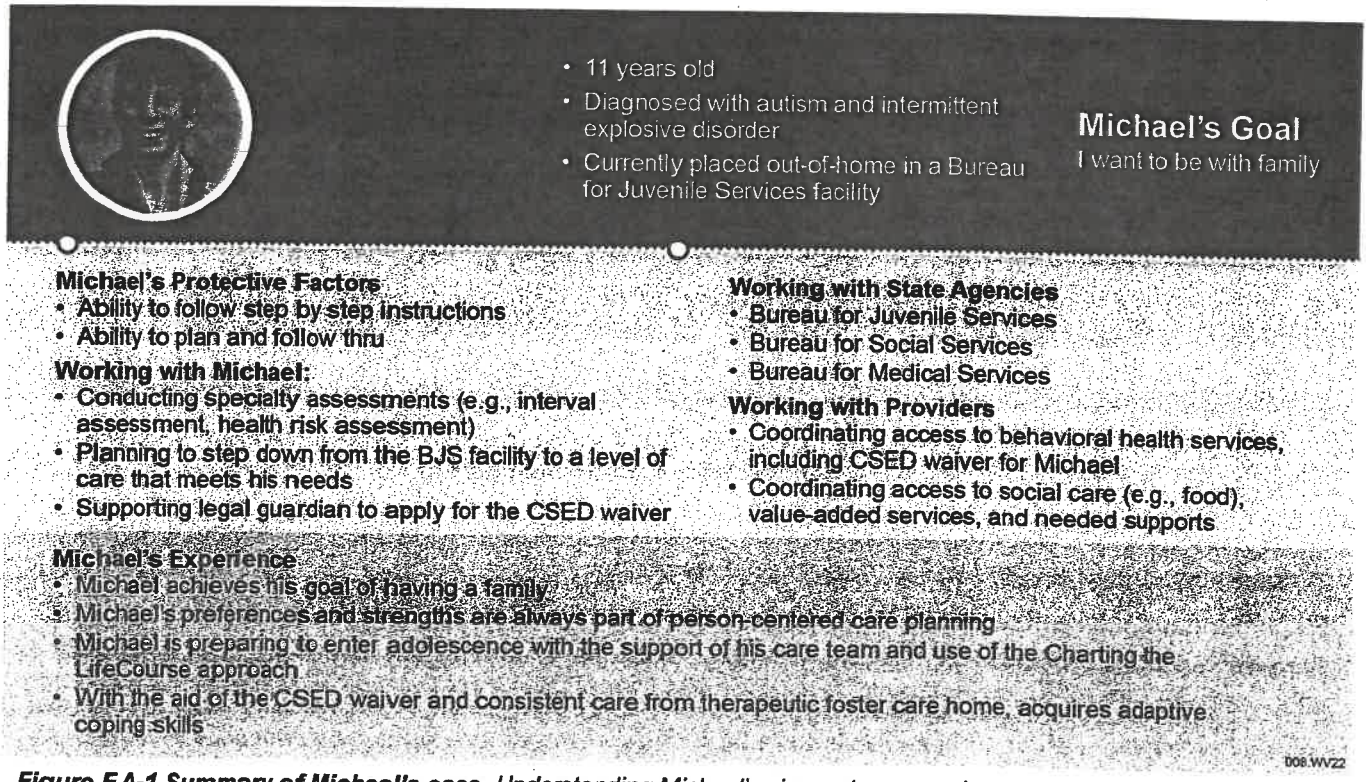


***Figure F.A-1 Summary of Michael's case.*** *Understanding Michael's circumstances and summary of his whole-person needs, Aetna makes sure that he has all the needed services and supports to avoid future placement disruptions using a comprehensive, person-centered approach to care coordination and close collaboration with his BSS worker.*

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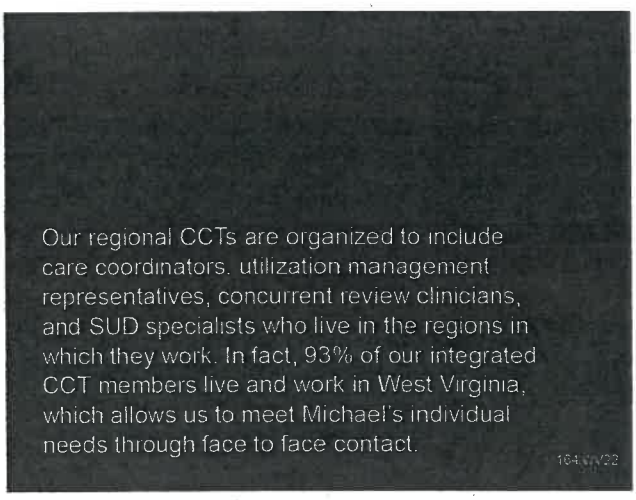
## Monitoring disruptions resulting in Michael's non-foster care placement

Aetna assesses member need as part of our Care Management program and our Care Advocate Team (CAT). We use our proprietary Consolidated Outreach and Risk Evaluation 2.0 (CORE™) risk analysis tool to monitor members in their service delivery journey to reassess risk levels. The care team, specifically BSS, caregivers, and other stakeholders engaged with Michael will monitor his care, review assessments, and access Michael's care plan in real time through our integrated electronic care management system and FamilyConnect 2.0, the platform for its external facing capabilities.




**Care management:** Aetna commits to providing children in the Mountain Health Promise program with consistent services focused on providing a continuum of care. Once Michael was enrolled as a Mountain Health Promise member, he was assigned care manager, Elizabeth, who is the central point of contact for all parties involved in his care. Elizabeth has expertise serving youth experiencing behavioral health crises and placement disruptions and has received specialized training from Aetna, including how to develop relationships with and engage Mountain Health Promise members and their providers in ongoing care. She has also received training specific to the diagnosis of autism spectrum disorder, foster-specific training focused on the **Aetna Care Advocate Team, Care Connections team (CCT) model**, and the process by which children and youth move in and out of BJS care. She has in-depth knowledge of the local providers and social resources available in Michael's community, as well as an understanding of local cultural dynamics. Elizabeth has been following Michael's case, documenting all information in our FamilyConnect 2.0 electronic care management system (described in detail below) for care team access. She has relationships with Michael's BSS worker, the residential treatment facility staff, and Michael, with ongoing communication with all. Michael has been stratified to the intensive (Level 3) care management tier due to the following reasons:

- Diagnosis of autism and co-occurring condition of intermittent explosive disorder; potential to have frequent episodes that can lead to placement disruptions
- Placement in a residential treatment facility, which may indicate a previous disruption has occurred since BSS places children first in a family setting. Since he is not in a family setting, he may have had a previous disruption, potentially causing a higher risk for additional placement disruptions

The following contacts and services are required for Michael, which are primary methods for monitoring placement disruptions:

- One face-to-face visit each month with Michael and separately with the BSS worker and providers at his residential treatment facility placement, or as requested by the DHHR. Elizabeth is assigned to support several Mountain Health Promise members at the facility, which Michael has been placed. This experience with the facility strengthens her relationship with staff and increases timely communication when a placement disruption occurs.

- One weekly contact (telephonic or via email) with Michael's legal guardian
- A minimum of two hours per week of care coordination
- At least one meeting with the interdisciplinary care team per month (refer to Figure F.A-2) to ensure they are aware of his status and are prepared for any care management changes

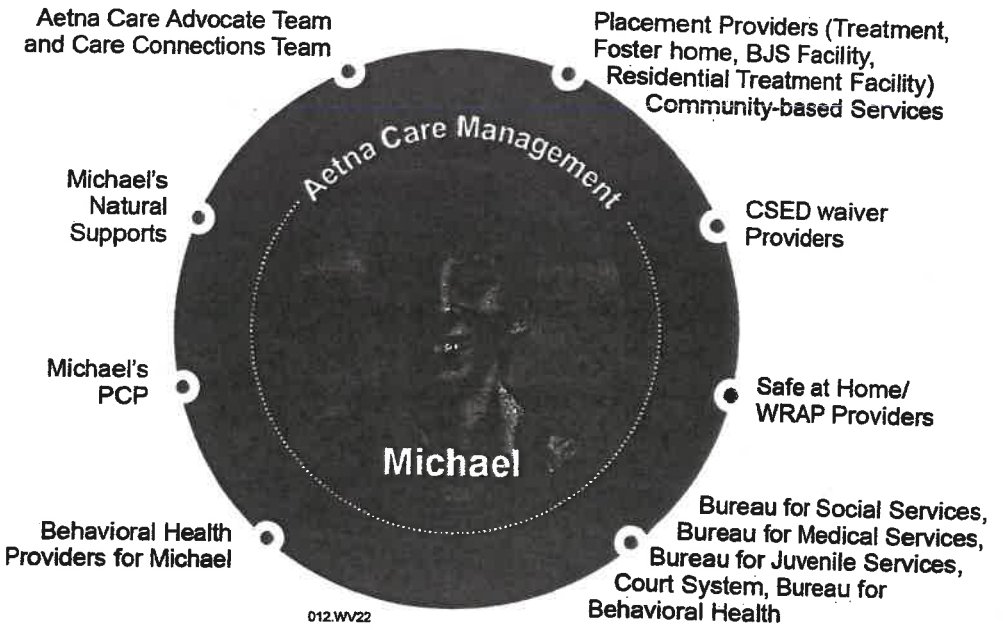



***Figure F.A-2 Michael's Care Team.*** *Michael's interdisciplinary care team fosters cross-system collaboration and whole-person services and supports to help him remain successfully in his new placement.*

- Regular contact with the residential treatment facility (as often as weekly, but on a schedule agreed upon with the facility) to get updates, including alerts if a placement disruption occurs; information shared by the facility, including Child and Adolescent Needs Strengths (CANS) updates and Child and Adolescent Functional Assessment Scale (CAFAS) score; progress and treatment notes, updated treatment plans, discharge planning updates, and documentation of completed EPSDT services
- Elizabeth and the care team (including his BSS worker, residential placement facility staff, and his circle of care) develop a crisis plan focused on identifying potential situations that could lead to disruptions

Elizabeth monitors the potential for placement disruptions by checking Michael's claims data for any hospitalizations, medication changes, or other triggers she should discuss with Michael's interdisciplinary care team during their regular meetings or to discuss with the BSS worker. Elizabeth also accesses our rising risk predictive model that identifies children and youth at risk for crisis episodes. This model can alert Elizabeth to potential crisis situations including potential disruptions from placement.

Aetna conducts daily admission rounds with care management and utilization management (UM) staff, allowing identification of a placement disruption to be communicated to Elizabeth in real time. BSS and BJS outreach Elizabeth the next business day to alert her to Michael's placement in a BJS facility.

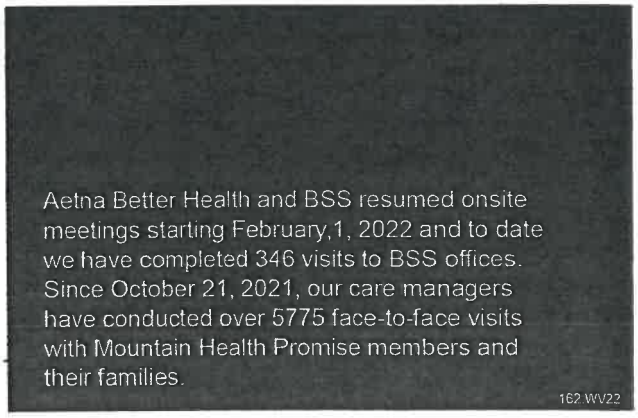
The Mountain Health Promise executive director and the behavioral health clinical consultant communicate regularly with BSS and BJS representatives. They meet at least weekly with the BSS assigned liaison, bi-weekly with the BSS regional program manager, and weekly with BJS. During these meetings they exchange information on youth without placement or youth with potential threat of disruption in their current placement.

**FamilyConnect 2.0:** Aetna care managers record placement disruptions, whether as the initial reason for enrollment or as a change in status, in their care management medical record. This information is shared with BSS today through the FamilyConnect system. FamilyConnect 2.0, is the enhanced version and will serve as the portal in which external interdisciplinary care team participants can access information such as assessments, care plans, crisis plans, and includes a record of placement disruptions. FamilyConnect 2.0 will deploy in 4th quarter 2022.

## 2. Communicating with the BSS caseworker and other supporting personnel

2. **Please describe the Vendor's communication protocol with the BSS caseworker and other relevant case personnel in this scenario.**

### Communicating with the BSS Worker:




According to established communication protocol, Elizabeth communicates weekly with BSS per the intensive care management tier requirement, as well as sending monthly updates with details on Michael's progress, including changes to care plan goals and the need to modify any interventions. As Elizabeth has been Michael's designated care manager since his enrollment in Mountain Health Promise, she has established strong professional rapport with his assigned BSS worker. The BSS worker has Elizabeth's office and cellular phone numbers, her email, and can use FamilyConnect 2.0 (both on a computer and via a mobile phone web browser) to contact her. She can arrange teleconferences via phone call or a web-enabled meeting service (e.g., Microsoft Teams) between the BSS worker, her Aetna colleagues, and the staff at his previous residential facility and/or the BJS facility staff. In addition, she can engage in secure email exchanges between the BSS worker and the other parties supporting Michael's care.

Even though Michael's enrollment in Mountain Health Promise is paused because of his BJS placement, Elizabeth still follows his case and facilitates information transfer. She remains the main point of contact for Michael's BSS worker. She incorporates additional Aetna team members, such as our Care Advocate Team and our behavioral health medical director, to assist with concerns around Michael's current needs and possible treatment options.

In the event the BSS worker is difficult to reach, Elizabeth has been trained on appropriate escalation process and follows these steps:

- If her call is not returned within 48 hours or the BSS worker's mailbox is full, she contacts Michael's BSS worker by email
- If she received no contact from the BSS worker within 48 hours, Elizabeth contacts the BSS worker's supervisor by email
- If no contact from the supervisor occurs within 24 hours, Elizabeth contacts their district Social Service Manager (SSM) by email, verifying the BSS worker's current contact number, and sharing dates of attempted worker and supervisor communication

- If after SSM intervention, Elizabeth still receives no communication from the BSS worker within 48 hours, she emails her Aetna manager
- The Aetna manager notifies the Mountain Health Promise care management director with details of the issue
- The care management director emails BSS Administrator of Mountain Health Promise, Office of the Commissioner, and the Mountain Health Promise executive director to resolve the communication issue

## Communicating with BJS:

The Aetna Mountain Health Promise behavioral health consultant and our Judicial CAT administrator meet weekly with BJS virtually to review the progress of all youth in detention, their court order status, and discharge plan. Since Michael was a prior Mountain Health Promise member, Elizabeth, the assigned care manager, also participates.

## Communicating with Michael:

Elizabeth communicates with Michael at least one time a month face to face, per the Intensive Care Coordination tier. She listens intently to Michael and his version of what happened, listens to his fears of what may happen next, and he communicates to her again that he really wants a family. He asks her frequently during their discussion where he will go and who will take care of him. He also expresses a high level of remorse for the event that happened. She learns that Michael is afraid of the older and bigger children and youth in the BJS facility and does not feel safe. She knows there is an urgency to move him as soon as possible due to his age to help him feel safe and achieve his goals.

## Communicating with Michael's natural supports:

If Michael has family support (not named in the scenario), Elizabeth engages them in communication and in Michael's treatment and service planning. If Michael does not have family, Elizabeth engages the child CAT administrator to coach the BSS worker to develop and use Family Finding techniques to identify additional family members to become involved in his care. Elizabeth supports BSS as they identify other individuals in Michael's support system, such as friends of the family, trusted community members, teachers and educational aides, and support group members, including peers among others. At Michael's request, and the approval of BJS, Elizabeth invites Michael's identified natural supports to participate in all interdisciplinary care team meetings, care planning meetings, and interval assessments.

## Communicating with Michael's providers:

Michael's providers include the treatment staff at BJS, those who were working with him at his residential treatment facility, his behavioral health specialist, autism spectrum disorder specialist, and primary care provider. With permission of BJS, Elizabeth ensures they are all aware of the information about Michael's case available to them via the electronic health record. She also provides them her multiple methods of communication (e.g., text, email, phone call, online messaging) for ease of communication. She invites providers at the previous facility to share information about what precipitated Michael's aggressive action to provide valuable insight to Michael's post-release residential treatment providers.

## Communicating with Aetna staff:

While Elizabeth is a specialist in Michael's areas of need (e.g., justice involvement, autism), she has the support of an entire regional interdepartmental Care Connections Team (CCT) that can support her

to identify the best care for Michael. Aetna is expert at defragmentation, leveraging our CAT model to coordinate across the child welfare and Medicaid delivery system. Some examples are:

- **Judicial CAT administrator:** The judicial CAT administrator serves as the single point of contact to communicate with the court and justice systems and serves as the point of contact at Aetna for Michael's BJS case worker. Elizabeth and the judicial CAT administrator remain in constant communication about Michael's case while he is in BJS custody. This communication ensures that Elizabeth is aware of the progress in removing Michael from BJS custody and transitioning into an appropriate treatment facility.
- **Child CAT administrator**: The child CAT administrator engages or identifies family to engage with Michael. Elizabeth coordinates with the child CAT administrator to invite these identified family members to join Michael's Care Connections team.
- **Placement Intervention team:** Through the regular monitoring that occurs via all the processes described above, we assign all members identified as at-risk for a placement disruption or who have experienced a recent disruption and are without a placement (i.e., staying at a hotel or in the county BSS office) to the Placement Intervention team. This team triages each member based on the potential of a placement disruption (e.g., a 10-day notice of removal) or when a child has been in a non-placement status for an extended period. This team initiates additional communication with the BSS worker or will schedule a Promise Project program special review (described in further detail below) to assist with accelerating an appropriate placement for the member.

## 3. Assisting the BSS caseworker to identify and secure treatment options

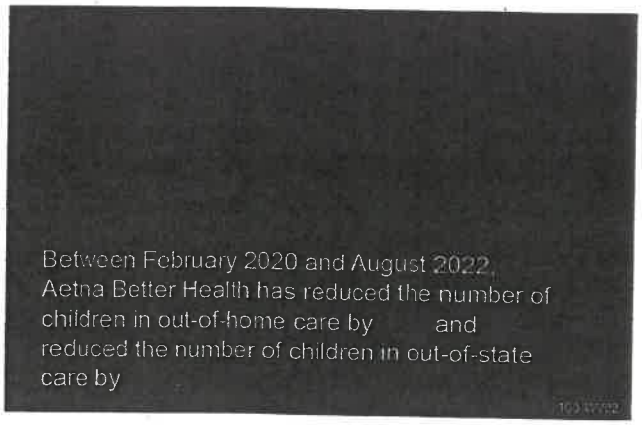
3. After the Vendor receives notification about the placement in BJS, how will the Vendor assist the caseworker in assessing Member A for appropriate services and identifying and securing additional treatment options and supports designed to meet the youth's needs to transition them from inappropriate, non-foster-care placements?

Because West Virginia legislation stipulated that Michael cannot be in a BJS facility because he is under 14 years old, Elizabeth and the judicial CAT administrator understand the need for his release as soon as possible. They take all necessary steps required to accomplish this. Elizabeth assists Michael's BSS worker to secure any necessary behavioral health services to obtain a forensic evaluation of competency, if ordered by the courts due to Michael's diagnosis. In addition, Elizabeth reviews all of Michael's available records to determine if an additional record search needs to occur. If so, Elizabeth will contact Michael's previous placement, any schools he has attended, and his previous providers to obtain records or information to provide to the court. These records could include his Individualized Education Plan, documents of his IQ, or a diagnosis of significant intellectual disability. If needed, Elizabeth involves our Medicaid member advocate to support Michael's rights.

Elizabeth reviews all Michael's recent interval assessments with the BSS worker. These include review of Michael's physical and behavioral changes, medical issues, any trips to the emergency department, medication additions or discontinuations, EPSDT needs, and social determinants of health. Elizabeth also reviews with the BSS worker the results of all additional assessments that have been completed, which could include but are not limited to: the CAFAS; other child-specific screeners and assessments for behavioral health, Adverse Childhood Experiences, and other issues affecting Michael. All of Michael's assessments are located on FamilyConnect 2.0, so they are available to the caseworker in an easy-to-access format. They discuss at-length Michael's diagnoses of autism and intermittent explosive disorder and review past situations that led to these diagnoses and the need to make sure Michael has a significant support system to facilitate a placement outside of BJS. This system includes

not only the people he may at some point live with but also connections to support his safety plan, treatment goals, and healthy development.

## Promise Project process to assist Michael with an appropriate placement




Aetna's The Promise Project is a unique review process we developed to assist Mountain Health Promise members with experiencing a wide range of challenging circumstances, such as disrupted placement, transition planning needs, step-down from BJS placement, among other complex issues. These special reviews can be triggered through the weekly Placement Intervention Team meeting and are typically conducted within 24 hours of request by anyone involved in the member's care and include the child/youth, parent, or caregiver, Mountain Health Promise clinical team, BSS staff, childcare providers, treatment facility staff, and other natural supports selected by the family. We submit written recommendations from these meetings, which are created using the "nothing about me without me" approach. We conducted over 200 special reviews from January through October 2022.

Based on her review of all available information with the BSS worker and her knowledge of Michael's strengths and goals, Elizabeth recommends bringing Michael's case to a Promise Project special review. Because of Michael's disrupted placement, critical clinical concerns related to his diagnoses, and the potential need for psychiatric residential treatment after his release from the BJS facility, his case is facilitated by our behavioral health consultant and integrated clinical team with oversight of the behavioral health medical director to help identify a potential placement.

In the special review process, Michael's case is prioritized based on a holistic range of factors, including his placement in the BJS facility, CAFAS score, current placement status, discharge plan, and permanency/reunification plan, among others. Each week the Placement Intervention Team triages the highest need cases for discussion. Because of Michael's unique circumstance, the judicial and child CAT administrators are key members of his special reviews. They assist with coordinating the participation of Michael's providers, with the permission of BJS.

The team participating in the special review develops recommendations for Michael's treatment, including all the services and supports he needs to return to the least restrictive and most integrated placement appropriate for his current needs, strengths, and preferences. For Michael, the goal of the special review process is to facilitate his successful placement with a family, including kin, or in a potential adoptive home.

## Treatment services recommended for Michael

A recommendation from the special review may include conducting a special "faces to cases" review, inviting specific providers who are able to meet Michael's needs to a specialized meeting to review and discuss their potential to serve Michael. In this process, Michael is highlighted with a biography of his strengths, what he likes, what he enjoys doing, and what his hopes and dreams are for the future. Michael is invited, as appropriate to his ability, to make an opening statement about what he wants in his life. This review focuses on the treatment and service needs identified to help Michael to be successful. Through this review process, potential providers get to know the best of Michael as well as his treatment needs. This facilitates the discussion of exactly what support a provider may need to

provide the best care for Michael. Elizabeth and team facilitate any additional information a provider may need to make a referral decision. An Aetna behavioral health navigator will be assigned to Michael's team to assist with the transition from BJS into his next placement. This behavioral health navigator will follow Michael's case intensely, meeting with him consistently, daily if needed, coordinating with Elizabeth and team, and ensuring that his transition into his new placement is as smooth as possible.

Elizabeth recommends to the BJS case manager to refer Michael to Kepro to begin the Children with Serious Emotional Disorder Waiver (CSED waiver) application process. The CSED waiver application starts Michael on the WV Pathway to Children's Mental Health Services, to determine which services can be provided to support Michael in his next placement and eventually the in-home services to allow him to live with a family. Elizabeth also coordinates with the BJS case manager, sharing Michael's whole health history, to make sure all medical, EPSDT, dental, and vision services are provided while in custody with BJS, and that he receives all his required medication.

Aetna leverages West Virginia significant wraparound resources available to Michael through various agencies, such as:

- **Bureau for Social Services:** Home- and community-based resources and services.
- **Bureau for Medical Services:** CSED waiver program to keep Michael from unnecessarily returning to a residential treatment facility once he has been placed with kin or an adoptive family. Elizabeth supports Michael's legal guardian to apply for the CSED waiver and the Intellectual/Developmental Disabilities Waiver (based on verification of his eligibility).
- **Bureau for Behavioral Health Children's Mobile Crisis Team Services through 1-844-Help4WV:** If Michael experiences another crisis, his caregiver or guardian can call the Children's Crisis and Referral Line to be connected to regional Mobile Crisis Response and Stabilization Teams. This call enables over-the-phone or in-person crisis de-escalation support or respite services. Members have 24/7 access to 844-Help4WV's crisis and non-emergency behavioral health and substance use services via calls, texts, online chats, or emails.
- **Bureau for Social Services Safe at Home West Virginia program:** This program provides informal (i.e., community-based and family) supports, case management, in-home therapy, and positive behavior supports.

Our role is to help Michael and all Mountain Health Promise members and their families to access the State's valuable resources and supplement them with additional Aetna Value-Added Services, while coordinating the use of appropriate covered benefits. The benefits available to Michael include:

- Behavioral health navigator services, in which the navigator works toward placing Michael in the least restrictive and most integrated setting where his needs can be met, by personally advocating for him and setting up interviews with potential placements, with services continuing until a safe, secure, and appropriate placement is found and Michael has transitioned there, staying with Michael's case for 90 days or more as needed.
- Autism supports, available in a residential treatment facility, in school, at an out-of-home placement, or in the home with a foster family, or kin
- Physical health care services, including primary and preventive care (e.g., EPSDT visits, vaccinations), including support for virtual care via telehealth
- Educational supports, according to the individualized education plan

- Behavioral health services include ongoing psychiatric evaluation and psychotropic medication monitoring (if applicable), functional behavioral analysis, individual and group counseling, psychosocial rehabilitation, and skills training and development, etc.
- Pharmacy supports, such as the Children's Healthy Administration of Medications Monitoring program
- Value-Added Services, such as participating in the Ted E. Bear, M.D. club (refer to Figure F.A-3), home delivered meals when entering a new placement, legal supports, incentives for health behaviors, and our Calming Comfort collection, which provides members the option to order supplies to help calm the impact of trauma. Items include a sound machine, aromatherapy, light therapy
- Products, and weighted pillows/blankets
- Socially necessary services such as Connection Visits and transportation services once a family is identified. These services will help to transition Michael into a family setting slowly while meeting his need to feel safe during changes to his routines.
- Community participation needs, peer support services, and connection time between Michael and natural supports in his placement and in the community



***Figure F.A-3 Ted E. Bear, M.D.*** *Ted E. Bear, M.D. visits children throughout West Virginia to promote healthy choices and activities.*

- Caregiver support needs (e.g., training on understanding autism and de-escalation techniques for children with intermittent explosive disorder)
- Support services for caregivers of children with autism, including access to respite care
- Family Finding techniques, led by the child CAT administrator, and including the BSS worker who is trained on the process, to identify additional kin to provide consistent love and contact throughout Michael's journey. Elizabeth seeks permission from BSS to include located family in Michael's interdisciplinary care team and special reviews.

For all the services described above, Elizabeth will coordinate with the BSS worker to provide education about their availability and assist with referrals and follow-ups. Elizabeth will continue to provide intensive level care management to Michael, to conduct monthly care plan updates, interval assessments and reassessments, and make monthly contact with the caseworker to provide details on Michael's status and progress.

## Summary

Aetna offers Michael a trauma-transformed, youth and family-integrated system of care. In doing so, our care advocate team supports Mountain Health Promise goals of delivering needed supports and services in the most integrated setting possible while providing a continuum of care services to address his physical health, behavioral health, social, and family needs, if his family is involved in his life. For Michael, the trauma informed care framework Aetna uses will enhance the use of local community-based services and strengthen his natural network of support. These services and support will help meet his needs and make sure he can receive the services and supports he needs to thrive in the least restrictive and most integrated setting possible. With the ongoing support of Elizabeth and his BSS worker, Michael has the chance to step down into a kinship or adoptive placement in time.

# Attachment F: Sample Case Scenario B

**2. Member B Case Scenario**

Member B is 14 years old and has an Intellectual/Developmental Disability (I/DD) diagnosis. Member B is taken to a BJS facility in the middle of the night after being charged with domestic battery for physically assaulting their mother, causing injury. Member B is removed from the home, placed in the custody of BSS, and enrolled in MHP. The Department is court ordered to obtain a forensic competency evaluation of Member B. The Vendor will use the evaluation to recommend services in the least restrictive setting that serves the needs of Member B.

## 1. Supporting Member B (Taylor) return home

1. What steps will the Vendor take to coordinate the assessment of the child's ability to remain safely in their home and ensure intensive supportive community services?

The Mountain Health Promise team collaborated with the Bureau of Juvenile Services (BJS) in designing a process to identify members as early as possible in member transition planning. The process includes a weekly list in addition to a weekly meeting between BJS and Mountain Health Promise. The team determines engagement of additional stakeholders based on Taylor's unique needs identified during the initial intake assessment. We became aware of Taylor and their situation when we received the BJS weekly transition list. Our Judicial Care Advocate Team (CAT) administrator entered Taylor into Aetna's tracking system that documents children in BJS custody who will soon become Mountain Health Promise members. After entering them into our system, our Judicial CAT administrator begins reviewing all Aetna systems to gather any known information available on Taylor and enters it in their record. We then assigned an Aetna care manager (Judy) to Taylor, and Judy begins to prepare for our weekly transition meeting with BJS to discuss the plans for children in BSS custody.

During the weekly call, Judy learns Taylor had been removed from their home for assaulting their mother in a middle-of-the-night episode of violence, was placed in BJS custody pending the completion of a forensic competency evaluation and will also be placed in the custody of BSS. Judy learns during this weekly BJS meeting that assistance is needed to identify Taylor's ability to remain safely in the family home. Judy refers Taylor to the Placement Intervention team to determine if a special review should be scheduled to determine placement recommendations. A special review will bring all of Taylor's engaged team together, including Taylor, their parents, BJS, BSS, providers and other stakeholders who bring their area of expertise into the review. Taylor and their family bring their own expertise and share what they need. As part of this review, several recommendations may occur, including the necessary services to help Taylor stay at home.

Following the weekly BJS transition meeting, Judy collaborated with the BSS caseworker to identify and connect Taylor to all necessary services, such as those available through the Intellectual/Developmental Disabilities (I/DD) Waiver, Children with Serious Emotional Disorder (CSED) waiver, behavioral health services, treatment services, educational services, and medications, in the least restrictive setting possible.

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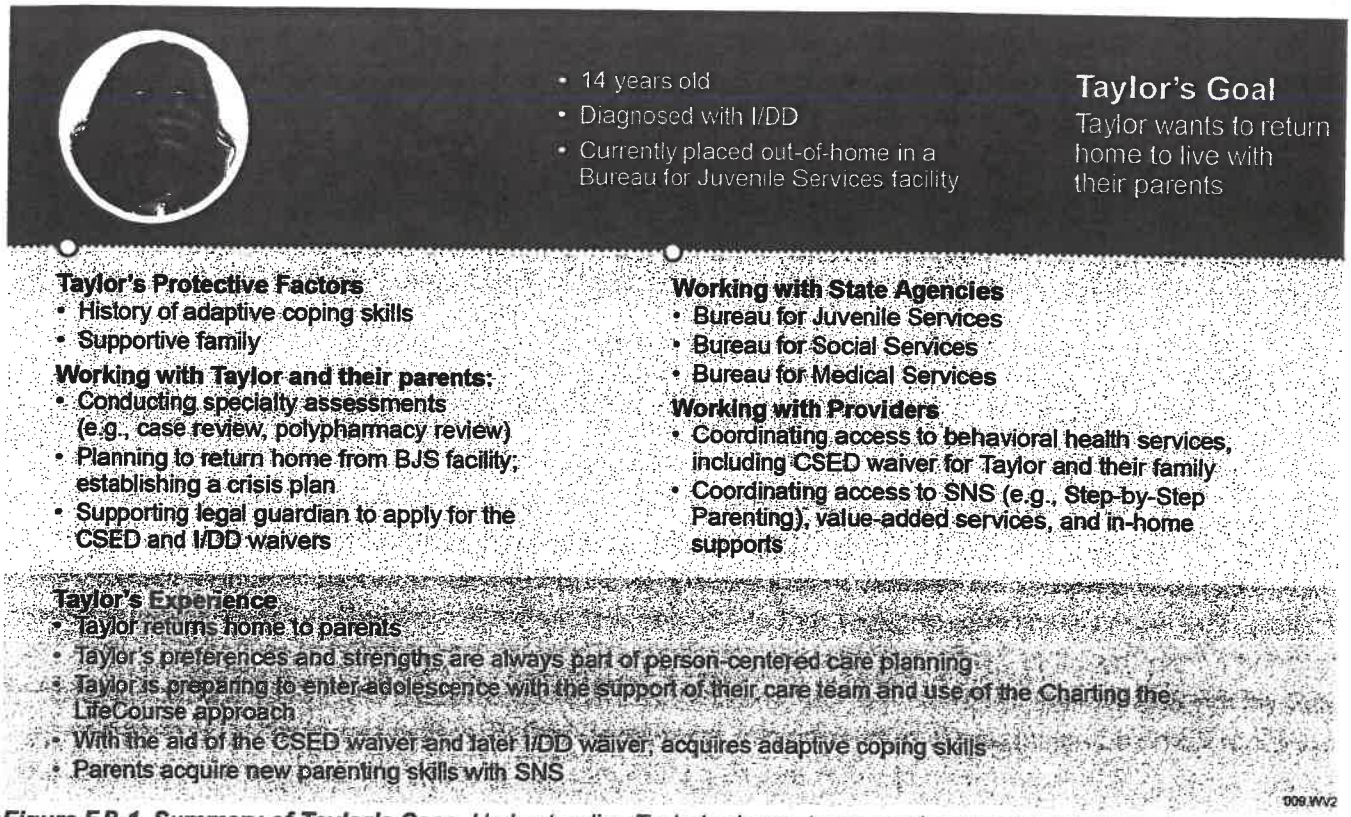


***Figure F.B-1. Summary of Taylor's Case.*** *Understanding Taylor's circumstances and summary of their whole-person and family needs, Aetna makes sure that they and their family have all the needed services and supports using a comprehensive, person-centered approach to care coordination and close collaboration with child's BSS worker.*

Coordinating the assessment of Taylor's ability to remain safely in their home and ensure intensive supportive community services. Because Aetna has worked with Mountain Health Promise youth like Taylor since 2020, we understand the feelings, fears, and anxiety a situation like this causes for the child and their family when dealing with trauma of this nature. Our teams are trained in trauma informed care and motivational interviewing specifically to assess, engage, and educate all members of a care team during stressful situations like this.

Our first steps in coordinating the assessment of Taylor's ability to remain safely in their home and ensure intensive supportive community services involve:

- Identifying Taylor's placement in the BJS facility and facilitating enrollment in Mountain Health Promise
- Assigning Taylor to the appropriate level of care management in anticipation of their release from the BJS facility and enrollment in Mountain Health Promise
- Assessing Taylor's ability to return safely home
- Ensuring intensive supportive wraparound community-based services

## Care Management

Taylor is assigned to Judy as their dedicated care manager. Judy has experience serving youth diagnosed with I/DD, coordinating with forensic competency evaluators, and supporting families to complete I/DD waiver and CSED waiver applications. Judy has worked with individuals with I/DD for five years, having worked in the advocacy arena before becoming a care manager with Aetna. Judy is a Licensed Independent Clinical Social Worker. She is specifically trained on **Charting the LifeCourse**

framework, originally designed by the University of Missouri Kansas City University Center for Excellence in Developmental Disabilities. This framework is designed for work with individuals with an I/DD diagnosis and utilizes tools to organize family voice and choice with vision, ideas, goals, problem solving, system navigation, and resource advocacy.

Judy recommends to the BJS case manager to refer Taylor to Kepro to begin the I/DD waiver and CSED waiver applications concurrently. Recognizing that the I/DD waiver application process has a longer period (90 days vs 35 days) for approval and often has a waitlist, Judy recommends applying for the CSED waiver concurrently. The CSED waiver application will start Taylor on the WV Pathway to Children's Mental Health Services to determine which in-home services can be provided to support Taylor to return home safely. Judy also coordinates with the BJS case manager to make sure all medical, dental, and vision services are provided while in custody with BJS.

Once Taylor leaves the BJS facility and enters BSS custody, they are enrolled in Mountain Health Promise. They are enrolled into our care management program through our assessment processes. Since Taylor is a newly enrolled member, Judy follows the Mountain Health Promise First in Care program and arranges all required medical appointments, dental, and vision care appointments that Taylor needs. Judy also coordinates delivery of a Member Handbook, Member ID card, and all other new member processes are followed and discussed. As part of the First in Care program and with permission of BSS as the custodian, the Mountain Health Promise family peer support specialist, Ginger, will outreach to Taylor's parents. As a person with lived experience, Ginger understands how these recent events have impacted the family. Not only has Taylor been placed in BJS, but Taylor is also now in the custody of BSS. Taylor's mom has sustained a recent injury during the incident and may be experiencing her own trauma. Taylor's mom may be experiencing sadness, anger, frustration, and be overwhelmed. Ginger understands the next steps that are coming for the family and can support as well as educate Taylor's family on how to navigate.

**Assessing Taylor's Ability to Return Safely Home:** For a young person who has experienced trauma like Taylor, Judy finds ways to minimize the need for them to recount painful events multiple times. This is particularly important for youth who are involved in multiple systems, such as BMS, BJS and BSS. Youth and families may become overwhelmed with providing responses to various screeners and assessments repeatedly. To reduce any trauma associated with answering questions on these assessments/screeners, as well as to reduce redundancy and duplicative efforts, Judy reaches out (with the authorization of BSS, Taylor, and their parents) to previous providers, schools, and sister agencies to obtain the results of their assessments and screeners and populates information into the initial health risk assessment. For example, Judy obtains authorization from BSS to contact Taylor's school to procure an Individualized Education Program (IEP) record to learn more about Taylor's educational history and experiences.

Judy then meets with Taylor and their parents within 24-72 hours of learning of their placement in the BJS facility and transition into BSS custody. During this meeting, Judy completes the rest of the health risk assessment and engages Taylor and their parents in a comprehensive, whole-person assessment. As Judy enters information from the health risk assessment into the electronic care coordination system, the responses re-populate in the comprehensive assessment. Using an algorithmic approach, the system provides suggestions to Judy about additional detail to solicit during the in-person comprehensive assessment process. In addition, knowing that Taylor and their family want Taylor to return safely to the home, Judy proactively connects with Ginger, the family peer support specialist to assesses Taylor's parents for needed services, such as additional treatment related to the mother's injury and their social needs (e.g., access to food and housing support) and any other community

resources they may have. Due to their removal from the home, their diagnosis of I/DD, and the initiation of BSS custody, Taylor qualifies for the intensive level of care management.

Judy will use the evaluation results of the range of assessments described above to determine whether Taylor can reside safely in the family home or a kinship living arrangement, or if their needs are enough to require placement in a residential treatment facility.

With the authorization of Taylor's parents/guardian, we share all screening and assessment results in real time (or upon BSS request) with their assigned BSS caseworker via our FamilyConnect 2.0 electronic health record, which allows the BSS case worker, Taylor's parents, and other individuals connected to Taylor to have access to care plans, crisis plans, assessments and other health records with appropriate permission. These results can also be sent by mail or securely via email upon request, as authorized by the guardian.

## Ensuring Intensive Supportive Community Services

Judy uses **Charting the LifeCourse** principles in developing Taylor's individualized care plan. The LifeCourse framework is an evidence-based approach that is specifically designed for individuals with I/DD. It guides care planning conversations using principles supported by research and outcome data to effectively serve individuals with I/DD. Planning discussions address not only care needs but important life goals and objectives that promote self-efficacy, community integration, educational goals, and participation in socially rewarding life activities. In addition, Aetna adopts a wraparound-informed model to service delivery ensuring compatibility with the DHHR's Pathway to Children's Mental Health Services, which can include Safe at Home services for the family, Children's Mental Health Wraparound and incorporates a Family Finding approach to family engagement. With these tools, Judy collaborates closely with Taylor and their family to identify key life stages and provide thoughtful anticipatory guidance around major milestones to sustain members' quality of life, avoid unnecessary transitions, and ensure continuity of care. In addition, Judy reviews the results of the Child and Adolescent Needs and Strengths (CANS) assessment, conducted by the BSS case manager, and Judy incorporates any relevant details into Taylor's care plan. Judy also appends the Youth Services Safety plan, completed by the BSS case manager, to the care plan.

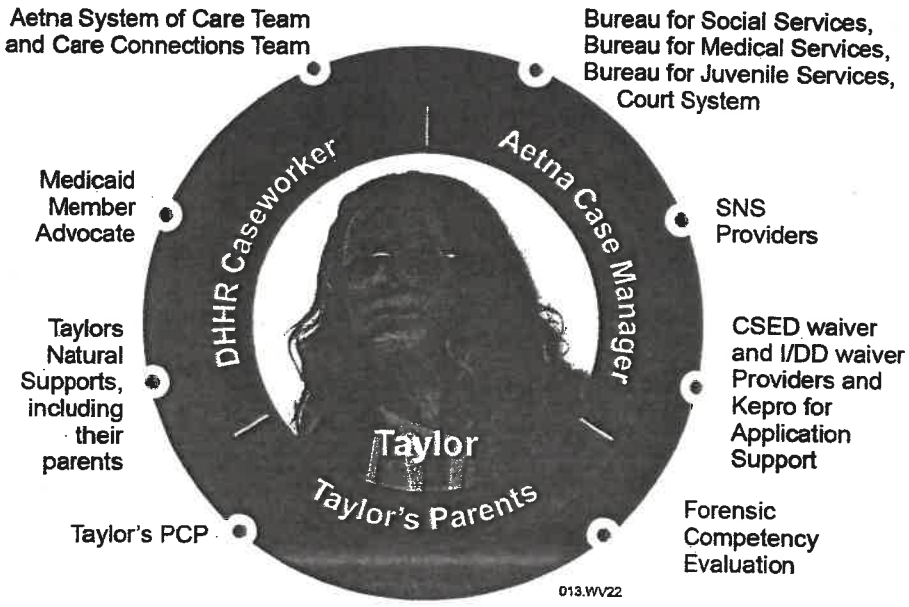


***Figure F.B-2 Taylor's Care Team.*** *Taylor's care team fosters cross-system collaboration and whole-person and whole-family services and supports so they can achieve their goal of returning home*

Through the individualized care planning approach, guided by person- and family-centered thinking, Judy, Taylor, and Taylor's parents identify all the supportive community services required for Taylor to live safely at home again, pending the outcome of their forensic evaluation. These services include:

- **Bureau for Behavioral Health Children's Mobile Crisis Team Services through 1-844-Help-4WV:** If Taylor experiences another crisis, their parents can call the Children's Crisis and Referral Line to be connected to regional Mobile Crisis Response and Stabilization Teams for over-the-phone or in-person crisis de-escalation support or respite services. Members have 24/7/365 access to 844-Help4WV's crisis and non-emergency behavioral health and substance use services via calls, texts, online chats, or emails.
- **988 Suicide and Crisis Lifeline:** Judy provides Taylor and their parents the 988 number that can connect them to a local call center for suicide crisis assistance.
- **CSED** waiver services, which include services relevant to their current age and provide interim support while waiting for approval for I/DD waiver services:
  - Wraparound facilitation
  - In-Home family support
  - Family therapy
  - Specialized therapy
  - Mobile response
  - Non-medical transportation
  - Peer parent support
  - Assistive equipment
- **I/DD** waiver services, which include but are not limited to:
  - Assistance to help manage behavior (behavior support)
  - Case management
  - Support that focuses on the member
  - Crisis services
  - Electronic monitoring
  - Assistance to give caregivers a break
  - Changes to homes and vehicles that make life easier for members
  - Transportation services (i.e., help with rides to and from services included in Taylor's plan)
- **Safe at Home** program services (e.g., Wraparound facilitator, child and family team, formal, informal supports, etc.)
- **Socially Necessary Services** for Taylor's parents, such as SNS Individualized Parenting aimed at improving parental competence and knowledge specific to the parents' needs when addressing Taylor's physical aggression. SNS cannot be provided along with Safe At Home without a waiver. Kepro would work with the BSS worker to ensure the appropriate waiver was in place before Individualized Parenting was granted a prior authorization.

## 2. Coordinating Assistance in Applying for the I/DD Waiver

2. Since the member may be eligible for the waiver, how will the Vendor coordinate assisting the child's caregiver and caseworker in applying for the waiver on behalf of the child?

To coordinate assistance in applying for the I/DD waiver, Judy sends Taylor's Legal Guardian (which could be Taylor's parents, or a BSS case manager) a copy of the waiver application for completion. Judy cannot complete this form on behalf of the Legal Guardian but can assist with collecting records from BJS, the IEP, psychological evaluations, or other records to facilitate the waiver application. The application collects basic demographic information and the Legal Guardian's signature indicates their approval for Taylor to be evaluated for the program. The Legal Guardian can submit the completed

application to Kepro directly as the Administrative Services Organization that oversees the I/DD waiver program for BMS or Judy can assist with application submission if requested.

The medical eligibility process for I/DD waiver can take up to 90 days from application submission to eligibility determination. If the Legal Guardian signs a Release of Information, Judy can contact Kepro directly to see where Taylor is in the eligibility determination process as there are several steps involved. If the Legal Guardian does not do this, Judy can coordinate with other internal Aetna resources, such as the children's CAT administrator, who can offer peripheral support such as education on the steps involved. Judy's primary role is to assist BSS with coordination of the concurrent CSED waiver and I/DD waiver applications. If Taylor has returned to their family home, a kinship placement, or other community placement, and the process takes up to 90 days, Judy can refer to several different programs or services that may assist Taylor and their family in the interim. These include:

- CSED waiver services, if the application has been accepted, which are described in detail above
- Referral for Positive Behavior Support Services through West Virginia University Center for Excellence in Disabilities
- Coordinate a referral to Safe at Home with the BSS caseworker
- Referral to the Lending Library through West Virginia University Center for Excellence in Disabilities, which offers educational materials and access to assistive equipment that Taylor may borrow. For the I/DD waiver population this could be communication devices as an example, but they have a lot of different things that can assist.
- Ensure Taylor's parents have the 844-Help4WV phone number so they can access mobile crisis response services if needed or respite services if needed in the interim.
- Linkage to physical, occupational and/or speech therapies as needed and appropriate for the individual member, which is available through the Medicaid State Plan
- Referral to outpatient behavioral health services through Chapter 503 for mental and/or behavioral health support.
- Referral to medical specialists to assist in the medical care of Taylor in the interim and overall
- Referral to Disability Rights of West Virginia if they need advocacy support
- Involvement in Family Finding, with the permission of Taylor's parents, to support and build a network for Taylor and their parents, utilizing Family Seeing tools and ConnectOurKids. The children's care advocate team administrator assists the BSS caseworker in locating any siblings or other family members (aunts, uncles, grandparents, cousins, etc.) and coaches the worker on outreaching the family members to arrange a family network meeting to discuss the needs of Taylor and their parents.
- Through the Aetna Shared Parenting program, Taylor's parents receive mentorship, support, and resources as they work towards preventing out-of-home placement and maintaining a safe living environment. This support offers a parent peer support specialist to pair with the parents and help support and assess needs of the parents to provide appropriate resources.

If Taylor is denied the I/DD waiver, there is an appeal process that Judy can inform the Legal Guardian (i.e., Taylor's parents or the BSS case manager) of their right to pursue. The denial letter will outline these processes, and waiver specialists at Aetna are available to provide additional support on the process, if necessary, so Judy can continue to act as a single point of contact for Taylor and their family.

If Taylor is approved for the I/DD waiver, they will more than likely be placed on a waitlist until the slot becomes available, which can sometimes take several months. If Taylor is still under the care of BSS while on the waitlist, Judy continues to monitor treatment progress at Taylor's placement and educates the BSS case manager on the waitlist support grant application (described in more detail below). In addition, because Judy and members of the Aetna CAT have extensive relationships with providers in West Virginia, if the BSS case manager needs support to identify appropriate providers to meet Taylor's needs (e.g., a dentist who serves children with I/DD), we facilitate linkages to assist with timely access to needed care. If Taylor requires treatment in a facility, Taylor's parents can receive SNS Individualized Parenting or other SNS as deemed necessary by the BSS worker to help equip them with the skills and knowledge to serve Taylor's needs upon return home.

While Taylor is on the I/DD waiver waitlist, Judy continues to coordinate all services and supports Taylor needs and, when invited, to participate in BSS led multidisciplinary team (MDT) meetings. BSS may decide to bring together the MDT, which includes Taylor, their parents, and Judy, if invited by BSS, and other participants selected by Taylor and their family, which consist of their PCP, their natural supports, the Medicaid member advocate, the judicial administrator, representatives from BSS, SNS providers, and other parties invested in making sure Taylor and their family receive the integrated services and supports they need to achieve their vision of a good life. Judy continues to complete interval assessments and care plan updates, to provide progress reports for the BSS case worker, and to educate and assist Taylor's parents with the waitlist support grant application to Bureau for Behavioral Health (BBH). This grant offers a limited number of services available through the I/DD waiver program, such as case management, behavior supports, respite, and day habilitation. This application process is a little different, where the agency providing the services submits the application and supplemental documentation for the waitlist support grant. If Taylor needs assistance with finding an applicable agency, Judy can refer them to BBH. These providers also provide services for the I/DD waiver program. Judy can direct Taylor where to go to find available agencies if they cannot get this information from BBH.

Upon notification that the I/DD waiver slot is available, Judy communicates Taylor's change in Mountain Health Promise eligibility to the Legal Guardian. When the I/DD waiver slot opens, Judy educates the Legal Guardian of this transition from Medicaid managed care to FFS at the appropriate time.

## 3. Assisting the Caseworker to Identify and Secure Additional Behavioral Health Services to Obtain the Needed Forensic Evaluations

3. How will the Vendor assist the caseworker in identifying and securing additional behavioral health services to obtain the needed forensic evaluations when the youth has not previously been in foster care?

West Virginia has specific guidelines for supervision and treatment of persons with a diagnosis of I/DD involved in the criminal justice system, detailed in West Virginia Code §27-6A-1 et seq. Because of their diagnosis of I/DD, the court may waive the requirement for Taylor to remain in the BJS facility until the completion of the evaluation. If Taylor needs to remain in the BJS facility until their forensic evaluation of competency can be completed by an approved evaluator (e.g., a qualified forensic psychiatrist or a qualified forensic psychologist), Judy will maintain contact with BJS on the progress toward the completion of this evaluation. Had Taylor previously been in foster care, the BSS caseworker would likely have a record of their IQ, IEP, or psychological evaluation that would allow for a waiver of the competency evaluation and transition out of the BJS facility. Having not been in foster care previously, Judy coordinates with Taylor's parents and the BSS caseworker to locate records containing this

information for Taylor. This could also include reviewing the claims/diagnosis history received through Taylor's Medicaid member enrollment file to identify any previous psychological testing dates and reach out to the provider for copies of records if Taylor's parents do not have them. If there is missing information needed for the examiner to do the forensic evaluation of competency, Judy assists to get any necessary appointments required to obtain whatever information is missing.

If the court does not grant the waiver, Judy, as the central point of contact for Taylor's BSS caseworker, will use her existing relationships with qualified behavioral health providers to support the caseworker in coordinating any required behavioral health services to provide necessary information for the completion of the forensic evaluation, such as psychiatric or psychological evaluations, medical and pharmacy history, her IEP, or histories of out-of-home care or residential treatment. If she faces any difficulties in locating the required behavioral health services, she can review Taylor's case through the weekly child welfare case round process. To expand her reach and get referrals to additional providers, by using our extensive behavioral health provider network, Judy can locate a qualified provider who can perform the forensic evaluation of competency timely.

## 4. Assisting the Caseworker to Identify and Secure Services Recommended by the Forensic Evaluation

4. **How will the Vendor assist the caseworker in identifying and securing any required services as recommended by the forensic evaluation, which may include treatment services, educational services, and/or medications?**

Upon the completion of a forensic evaluation by a qualified behavioral health provider, Judy assists the BSS caseworker to identify and secure recommended services through continuance of her care coordination responsibilities relative to Taylor's enrollment in the intensive level of care management. Judy reviews all recommendations made by the forensic evaluator and incorporates recommendations from Taylor's MDT, and all other assessments. She incorporates them into Taylor's care plan. Based on the care plan, Judy can refer Taylor and their family to resources such as:

- Behavioral health treatment, if Taylor is diagnosed with a co-occurring behavioral health condition (e.g., anxiety, depression,)
- Skills training and development, individual and group counseling, peer support services, psychiatric evaluations, etc.
- Medications and medication management
- School support (e.g., Taylor's IEP); speech and occupational therapy
- FAST Program (Family Advocacy, Support, and Training) through Legal Aid to engage Taylor and their family in the planning, management, and evaluation of Taylor's mental health treatment and service needs, including special educational requirements
- Respite care for Taylor's parents
- Parent support group
- Court-ordered treatment, such as placement in a particular facility

Depending on the recommendations of the forensic evaluator, Judy can also connect Taylor and their family to additional resources, such as the Medicaid member advocate to assist with any potential legal issues the family is facing, including educating them on our Value-Added Service for legal supports.

## Summary

As the current Mountain Health Promise plan, Aetna has experience and capabilities to coordinate high-quality, whole-person and youth- and family-centered care to our members, including those involved with the BSS care systems with specialized diagnoses, such as I/DD, forensic involvement, and traumatic experiences. Aetna offers Taylor a trauma-transformed, youth and family-integrated system of care, to support the strengthening of their family setting and natural network of support to help them meet their goals. Aetna's approach supports DHHR's goals of enhancing coordination and access to services, minimizing barriers for youth and families, decreasing the burden on accessing treatment, and increasing family-centered care that provides necessary and coordinated services to all members of the family.

# Attachment F: Sample Case Scenario

**3. Member C Case Scenario**

Member C is a 16-year-old male residing with his aunt as a kinship foster placement. Member C has been charged with a delinquency battery petition in juvenile court after an argument with his aunt escalated to physical violence. Neither the aunt nor juvenile were seriously injured. The juvenile's aunt is requesting the child be removed from the home and placed in another placement.

## 1. Member C Case Scenario Response

1. How will the Vendor assist the caseworker in demonstrating to the youth's aunt the ability of intensive in-home supports to serve the family as an alternative to residential treatment

### Supporting Kenny to return to his kinship placement

Kenny (Member C) is a Mountain Health Promise member that has recently demonstrated violent behavior resulting in his aunt requesting that he be removed from his kinship placement in her home and placed elsewhere. His situation requires that an Aetna care manager assist the BSS caseworker to help Kenny's aunt to understand the value of intensive in-home supports, which can be an alternative to residential treatment. We collaborate with all parties involved to support identification of and access to needed services. These can include immediate crisis and supportive services and necessary assessments and evaluations to determine what is needed to support Kenny's whole-person needs and his life goals. If Kenny is not able to remain in his kinship placement temporarily, we then ensure Kenny has the ongoing treatment, assessment, and discharge planning services needed to help him transition back home when they are both ready. See Figure F.C-1 for a summary of Kenny's case.

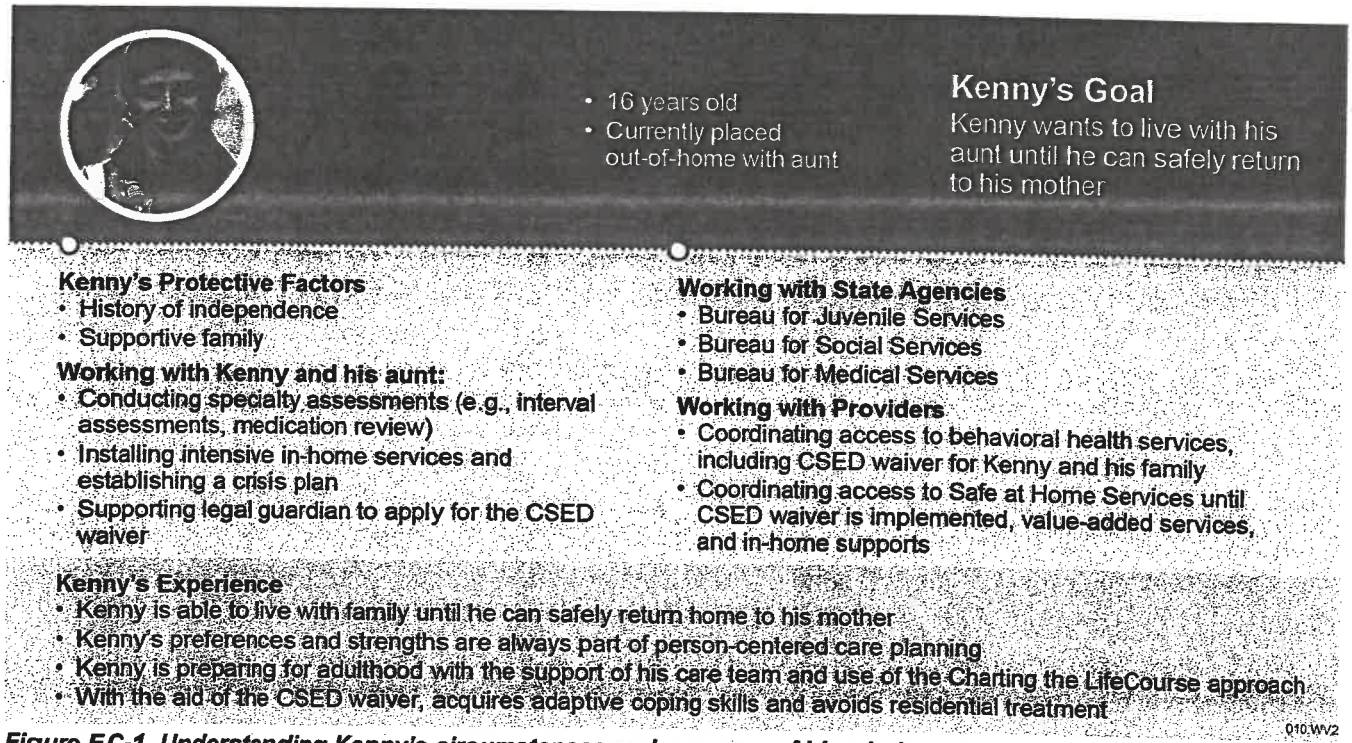


***Figure F.C-1. Understanding Kenny's circumstances and summary of his whole-person and family needs,*** *Aetna makes sure that he and his aunt have all the needed services and supports to avoid future placement disruptions using a comprehensive, person-centered approach to care coordination and close collaboration with his BSS caseworker.*

## Assisting the caseworker to demonstrate the value of intensive in-home supports

**We know Kenny and his aunt.** As a Mountain Health Promise member residing in kinship care, Kenny has an assigned care manager, Audrey, who acts as the single point of contact for Kenny, his aunt, his BSS caseworker, and his providers. Audrey is experienced in working with youth and family in kinship care and is familiar with the local resources accessible to Kenny and his aunt in their community.

Before his recent violent episode, Audrey was providing the supportive level of care management (Tier 2) and has developed rapport through regular contact with Kenny, his aunt, and his BSS caseworker, which included:

- One face-to-face visit with Kenny and his aunt each quarter, and as requested by BSS
- One weekly contact with Kenny and his aunt by phone or email by their preference
- One meeting with the interdisciplinary care team every 90 days
- One care plan update each month

Upon learning about the incident between Kenny and his aunt and the aunt's request that he be moved to an alternative residential treatment placement, Audrey immediately initiates a reassessment for Kenny. This process includes:

- Outreaching to Kenny's BSS caseworker to schedule a meeting with BSS to discuss how they can collaborate to assess Kenny's and his aunt's needs. They discuss the process to educate Kenny's aunt on the intensive in-home services available that could allow Kenny to remain in her care.
- Conducting a home visit to meet with Kenny and his aunt to complete a comprehensive reassessment with the goal of learning about changes in Kenny's life since his last assessment, and to understand additional needs arising for Kenny's aunt related to his recent violent episode.
- Conducting updated risk stratification for Kenny that incorporates results of his comprehensive reassessment and our Consolidated Outreach and Risk Evaluation (CORE™) proprietary and evidence-based risk stratification tool that uses time-tested analytic methods honed for more than 10 years and includes our rising risk predictive model that identifies children and youth at risk for crisis episodes.

Once the reassessment and risk assessment have occurred and Kenny has been stratified to a higher level of care management, the intensive level, Audrey, BSS, Kenny, and his aunt begin the care plan update that identifies other individuals who may be included in the care team. This update also begins to identify all potential services and referrals that could support Kenny to remain in the care of his aunt.

Audrey engages Kenny's aunt in person-centered planning, eliciting information on what triggered Kenny's violent episode. They discuss what could have worked to de-escalate the situation, and Audrey learns what it would take to make Kenny's aunt feel safe at home with Kenny again. Audrey discusses the services and supports that are available to both Kenny and to his aunt. These services are focused intensive in-home services, such as children's mobile crisis teams, an enhanced mobile crisis service through 844-Help4WV and CSED waiver services. The CSED waiver application will engage the WV Pathway to Children's Mental Health Services. Audrey also explains the Safe at Home services available during the CSED waiver application process. She explains to the aunt how Safe at Home services support them during the 35-day period waiting for eligibility of the CSED waiver program to be determined. Audrey can also talk to Kenny's aunt about Peer Parent Support, a service in the CSED waiver service array. This is a parent with lived experience and can provide a listening ear so that Kenny's aunt will feel less alone.

Similarly, Audrey engages Kenny in individualized, youth-centered planning, embracing the Charting the LifeCourse principles of person-centered thinking, to learn from Kenny's perspective what led to his violent episode and how it could have been prevented. Audrey asks Kenny about his vision of a good life and what steps he wants to take to achieve it. She outlines the intensive in-home services available to him so he can participate in decision making on which services will work best for him.

Kenny's relational breakdown with his aunt could become an additional risk factor for his future health and happiness. While his aunt believes Kenny's behaviors are no longer manageable in her home and require a specialty level of care, Audrey and the BSS caseworker work together to help Kenny's aunt understand that with intensive in-home services, respite services paired with the treatment services he needs, Kenny can remain safely with her instead of entering a residential placement.

## 2. Supporting the caseworker to identify and access services for Kenny's family

2. **How will the Vendor support the caseworker in identifying and accessing services for the family, including coordinating immediate crisis and supportive services and necessary assessments and evaluations to determine the ongoing service needs? How will the Vendor assure the family receives needed services identified through assessments and evaluations timely to prevent removal of the child from the home?**

Audrey supports Kenny's BSS caseworker to coordinate immediate crisis and supportive services that support Kenny's ability to remain in the care of his aunt. She and the BSS caseworker identify necessary assessments and evaluations that they can use together to determine Kenny's ongoing service needs.

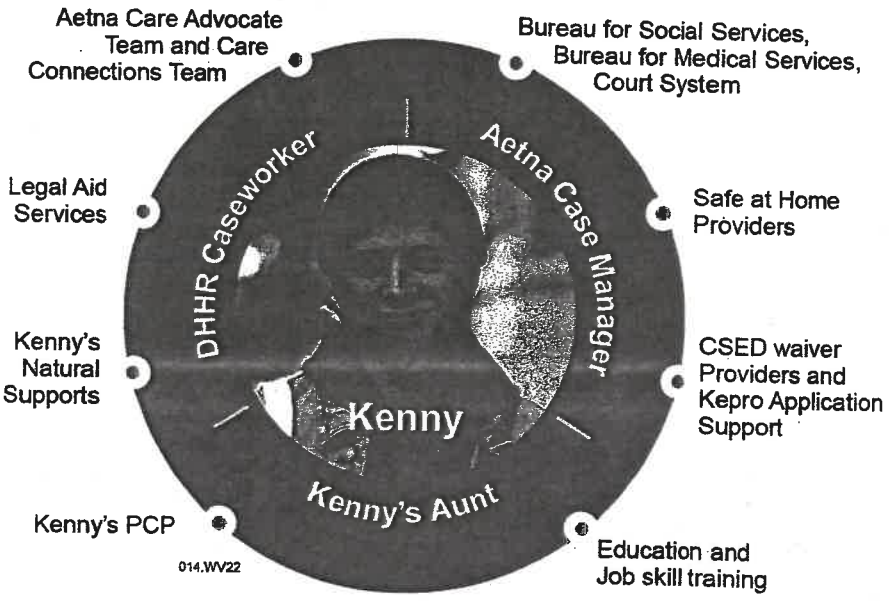


***Figure F.C-2 Kenny's care team.*** *Kenny's care team fosters cross-system collaboration and intensive in-home services, allowing him to remain in kinship care*

Coordinating immediate crisis and supportive services: As part of the intensive tier of care management, Audrey would take the lead to coordinate available services and supports including:

- **BMS Children with Serious Emotional Disorder (CSED) waiver services:** Audrey assists the BSS caseworker to refer Kenny to the CSED waiver program and coordinates with Kepro in gathering information from Kenny and his aunt in the application process and assessment pathway. Some of the CSED waiver services include in-home family therapy and support; guidance and support for family, parents, and caregivers; and short-term relief for primary caregivers through respite
- **BSS Safe At Home programming:** Until eligibility is determined for the CSED wavier, Kenny and his aunt can access the Safe at Home program, which connects families with a wraparound

facilitator who works with Audrey and the BSS caseworker to complete trauma-informed assessments and individualized planning. They coordinate to initiate wraparound services and evidence-based services and supports to help Kenny remain safely at home with his aunt.

- **Enhanced Mobile Crisis Services through 844-Help4WV:** If Kenny experiences another crisis, his aunt can call the Children's Crisis and Referral Line to be connected to regional Mobile Crisis Response and Stabilization teams for over-the-phone or in-person crisis de-escalation support. Members have 24/7/365 access to 844-Help4WV's crisis and non-emergency behavioral health and substance use services via calls, texts, online chats, or emails.
- **988 Suicide & Crisis Lifeline:** Audrey provides Kenny and his aunt the 988 number that can connect them to a local call center for suicide crisis assistance.
- **Referrals to providers:** Audrey refers Kenny and his aunt to providers if they do not have established care. She helps them to locate a PCP, community-based behavioral health services, including in-home and school-based counseling, psychiatrist, substance use counselor, dentist, and pharmacy, among others. Audrey helps to coordinate necessary appointments for recommended assessments (e.g., psychiatric assessment, substance use assessment), services and treatments, such as positive behavior support and anger management counseling. Audrey conducts regular follow up with Kenny's aunt and his BSS caseworker to confirm his attendance at appointments for his recommended services. When necessary, Audrey connects directly with providers to assist with expediting needed appointments for Kenny and his aunt.
- **BSS socially necessary services:** If Kenny and his aunt need to be reimbursed for travel to supervised visitation with his bio parents, or to court hearings and MDTs, Kenny's aunt can become an SNS provider for Private Transportation 1 and 2. This will enable her to seek reimbursement for transportation specifically related to Kenny's status of being a child in foster care.
- **Aetna Value-Added Services (VAS):** Audrey educates Kenny, his aunt, and the BSS caseworker on our Mountain Health Promise VAS. For example, Kenny can access our Connections for LifeTM program, in which Kenny can receive a free tablet, education and training around technology literacy, and help connect him to key local and national resources through a proprietary member portal. Kenny can use the tablet to attend virtual appointments with his providers, as well. Kenny can also access Pyx Health through his tablet. Pyx Health is an app that supports members around feelings of loneliness.

### Transition support services

Transition age youth services and supports prepare Kenny for becoming an adult, potential changes in his Medicaid eligibility, help to seek employment, help to pursue post-secondary education, and other supports all to help him meet his personalized goals identified in collaboration with Audrey using **Charting the LifeCourse** tools. Audrey can upload completed Charting the Life forms in the Care Documents section of FamilyConnect 2.0 to become part of Kenny's electronic health record for all the care team to have access.

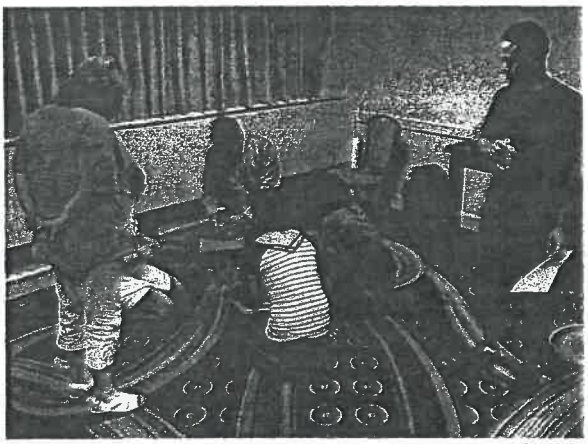

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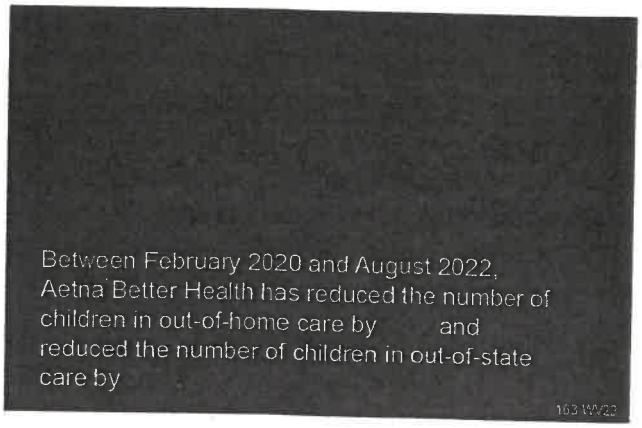
***Figure F.C-3: Aetna HEERO Workshop.*** *Aetna hosts HEERO workshops in West Virginia to give children and youth in foster care the opportunity to connect with peers.*

Helping Everyone/Each Other Reach Out (HEERO) Youth Workshop is a specialized service specifically engaged to help Kenny build a network of support of his choice to prepare him for transitions. (refer to Figure A.F-4)

Working for Success Job Corps can help Kenny complete his high school education, train for a meaningful career, and assist him with obtaining employment by providing technical skills training in 10-high growth industry sectors.

### Conducting necessary assessments and evaluations to determine ongoing service needs:

Aetna's electronic care management system for the Mountain Health Promise program, uses an algorithmic approach to populate assessment information. Audrey can leverage the additional identified assessments and evaluations that are recommended by the algorithmic approach, members of the ICT, which could include but are not limited to:




- ACEs questionnaire
- Child and Adolescent Needs and Strengths Trauma screen
- University of California Los Angeles Child/Adolescent Post-traumatic Stress Disorder Reaction Index
- EPSDT mental health assessment
- Care, Relax, Alone, Forget, Friends, Trouble (CRAFFT) screener
- Used, Neglected, Cut Down, Objected, Preoccupied, Emotional Discomfort (UNCOPE) screener
- Social determinants of health screening

Many of Kenny's assessments are located on FamilyConnect 2.0, and with specific permission to view, these assessments are available to the caseworker in an easy-to-access format. To respect Kenny's privacy, any assessment for SUD, behavioral health and/or HIV/AIDS status are masked from viewing unless he grants permission for specific individuals to have access. Any assessment information would be summarized in the care plan and available to the care team as a result.

### Ensuring Kenny and his aunt receive needed services timely:

Audrey, with the support of the interdisciplinary Aetna Care Connection team, comprised of representatives from the care management, quality management, and utilization management departments, will monitor Kenny's utilization of recommended services through our service coordination dashboards and claims systems. Audrey will receive alerts from the Aetna electronic medical record when there are gaps in services or when appointments are needed. The BSS caseworker, Kenny and his aunt all have access to the current services, upcoming appointments, gaps in care, and recommended preventive health services in FamilyConnect 2.0. This single source portal can assist all the team to ensure services are scheduled and provided in a timely manner.

## 3. Ensuring ongoing treatment, assessment, and discharge planning including needs to transition Kenny back to his kinship home

3. If the child is unable to remain in the home in this scenario, what steps will the Vendor take to ensure the ongoing treatment, assessment, and discharge planning includes the services necessary to transition the child back into their kinship home?

If Kenny is not able to remain in kinship placement with his aunt, Audrey continues to engage with Kenny, his aunt, and his BSS caseworker as part of his enrollment in the intensive level of the care management program. Audrey will regularly conduct ICT meetings and will present Kenny's case to integrated clinical case rounds when complex issues arise for which she needs the support of our Adult Care Advocate Team (CAT) administrator, medical directors, or others. Audrey engages in concurrent planning with the goal of making sure Kenny's ongoing treatment, assessment, and discharge planning needs are being met, while also planning for his return to his kinship placement.

**Ongoing Treatment:** Since Kenny is now stratified into the intensive level of care management, based on assessment of ongoing needs, Audrey increases her contacts with the BSS caseworker, with Kenny and his aunt, and with the staff at his placement. Intensive care management, the level for youth experiencing the most complex situations, such as placement disruption, provides the following:

- One face-to-face visit with Kenny, his BSS caseworker, and providers at his placement each month, and as requested by BSS
- One weekly contact with Kenny and his BSS caseworker by phone or email
- A minimum of two hours per week of care coordination, to make sure Kenny is receiving the services in the frequency, intensity, and duration indicated in his most recent treatment plan, including socially necessary services
- One meeting with the interdisciplinary care team per month
- Monthly care plan updates that continue to assess Kenny's ongoing needs, progress toward treatment and discharge goals

**Assessment:** As part of the ongoing treatment, Audrey and team continually assess Kenny's needs as well as his aunt's needs. Specific goals will be updated as progress occurs, and new treatment goals are identified.

**Discharge Planning:** Immediately upon his placement outside of his aunt's home, Audrey begins to engage the facility staff in transition and discharge planning, with the intention of supporting Kenny so he can return to a kinship placement.

Audrey will collaborate with the placement provider and BSS to make sure Kenny's Child and Adolescent Functional Assessment Scale (CAFAS) has been completed and updated. Kenny's CAFAS score is key to determining the level of care to best meet Kenny's needs.

In addition, as part of the discharge planning process, Audrey coordinates with Kenny's aunt, the CSED waiver Child and Family team, if applicable, and the BSS caseworker to make sure everything is in place to facilitate a safe and happy return home for Kenny. This includes providing Kenny's aunt with family peer support, either via Aetna's family peer support specialist or via CSED waiver services. In addition, if Kenny's aunt is a Mountain Health Trust member, she can enroll in care management to assist with accessing the services and supports she needs to care for Kenny in her home.

**Other Placement Options**: If Kenny's aunt is no longer able to keep Kenny in her home, Audrey works with the adult CAT administrator to develop a plan to engage Kenny and his aunt in Family Finding techniques to identify additional family members and arrange a family network meeting to identify an alternative kinship option rather than facility placement.

Additional examples of potential programs Audrey can present to Kenny's aunt are:

- Aetna's Shared Parenting program – Through the Shared Parenting program, Kenny's aunt will receive mentorship, support, and resources as they work towards preventing out-of-home placement and maintaining a safe living environment. A parent peer specialist with lived experience can provide support and education on how to navigate the system to help Kenny's aunt.
- Children's Home Society of West Virginia – Many kinship families need extra support as they provide care to children. The Children's Home Society of West Virginia strives to support kinship families by providing information, assistance with basic needs, training, support groups, care coordination, and connection to additional needed services.
- West Virginia Foster, Adoptive, and Kinship Network – Through this network, families receive advocacy and connection to needed resources. Families work together, supporting one another, and engaging in community efforts to provide each other with support.

## Summary

Aetna offers Kenny and his aunt a trauma-transformed, youth and family-integrated system of care. Our system of care paradigm supports BSS goals of reducing the number of children entering the foster care system through utilization of home and community-based services and delivering needed supports and services in the most integrated way possible. For Kenny and his aunt, our system of care framework supports the strengthening of their family setting and natural network of support to help them meet their goals and Kenny's transition into adulthood.

# Department of Health and Human Resources

## ATTACHMENT G: TERMS AND CONDITIONS RESPONSE TEMPLATE

### 1. INSTRUCTIONS

The Vendor should review Attachment G: Terms and Conditions Response Template, signing each provided signature block using blue ink in order to note the Vendor's acknowledgement and intent of compliance. The Vendor should identify any exceptions to the Terms and Conditions. If exceptions are not noted in Attachment G: Terms and Conditions Response Template of the RFP but raised during contract negotiations, the State reserves the right to cancel the negotiation if, at its sole discretion, it deems that to be in the best interests of the State.

### 2. RFP TERMS AND CONDITIONS

RFP Terms and Conditions consist of provisions throughout this RFP. Moreover, these provisions encapsulate instructions, State and federal procedures, and the State's expectations of the Vendor when submitting a proposal. The Vendor should understand and strictly adhere to the RFP Terms and Conditions. Failure to follow any instructions within this RFP may, at the State's sole discretion, result in the disqualification of the Vendor's proposal.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of these RFP Terms and Conditions.

Todd White  10-17-22

Printed Name / Signature of Authorized Personnel — Date

## 3. STATE CUSTOMARY TERMS AND CONDITIONS

The selected Vendor will sign a contract with the State to provide the goods and services described in the Vendor's response. The following documents shall be included in any contract(s) resulting from this RFP:

- Section 3: General Terms and Conditions (attached PDF file Section_2_Instructions_To_Vendors_Submitting_Bids_and_Section_3_General_Terms_and_Conditions)
- Section 7: Federal Funds Addendum
- Appendix 3: Service Provider Agreement (SPA)
- Business Associate Agreement

Please provide a signature stipulating the Vendor's acknowledgement and complete review of these documents.

Todd White — 10-17-22

Printed Name / Signature of Authorized Personnel — Date

If the Vendor is not taking exceptions to any of the State Customary Terms and Conditions, then the Vendor needs to provide a binding signature stipulating its acceptance of these documents.

Todd White — 10-17-22

Printed Name / Signature of Authorized Personnel — Date

## 4. MANDATORY REQUIREMENTS AND TERMS

The following items are Mandatory Terms and Documents. Please be advised, the Vendor should provide its affirmative acceptance of these items in order to move forward with consideration under this RFP.

- Attachment D: Mandatory Requirements (attached Microsoft Excel file, Attachment D – Mandatory Requirements)
- Attachment B, Section 2: Mandatory Qualifications
- In no event shall the State agree to terms that (a) require indemnification by the State of the Contractor; (b) waive the State's right to a jury trial; (c) establish applicable law anywhere other than the State of West Virginia, or jurisdiction in any venue other than the applicable court; (d) designate a governing law other than the laws of the State of West Virginia; (e) constitute an implied or deemed waiver of the immunities, defenses, rights, or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution; (f) limit the time within which an action may be brought; (g) require arbitration; (h) require the ability to defend lawsuit without the approval of the Attorney General's Office; or (i) pay attorney fees.
- Business Associate's Agreement

Vendors that are not able to enter into a contract under these conditions should not submit a bid.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of the Mandatory Requirements and Terms stipulated in this section.

Todd White — 10-17-22

Printed Name / Signature of Authorized Personnel — Date

## 5. COMMERCIAL MATERIALS

The Vendor should list any commercial and proprietary materials it will deliver that are easily copied, such as Commercial Software, and in which the State will have less than full ownership ("Commercial Materials"). Generally, these will be from third parties and readily available in the open market. The Vendor need not list patented parts of equipment.

N/A

## 6. EXCEPTIONS

The Vendor should indicate exceptions to the State's Terms and Conditions in this RFP. Any exceptions should include an explanation for the Vendor's inability to comply with such term or condition and, if applicable, alternative language the Vendor would find acceptable. Rejection of the State's Terms and Conditions, in part or in whole, or without any explanation, may be cause for the State's rejection of a Vendor's Proposal. If an exception concerning the Terms and Conditions is not noted in this response template, but raised during contract negotiations, the State reserves the right to cancel the negotiation, at its sole discretion, if it deems that to be in the best interests of the State.

The terms and conditions of a Vendor's software license, maintenance support agreement, and service level agreement, if applicable, will be required for purposes of contract negotiations for this project.

Failure to provide the applicable Vendor terms, if any, as part of the RFP response may result in rejection of the Vendor's Proposal.

Instructions: Identify and explain any exceptions to the State's terms and conditions using the tables provided below, adding tables, as needed. If no changes are listed, the Vendor is indicating that no changes to the Terms and Conditions are proposed, and that the Vendor intends to accept them as written if the Vendor's Proposal is selected. Mandatory Requirements and Terms noted in this RFP are non-negotiable.

- The Vendor may add additional tables, as appropriate.
- Do not submit Vendor's Standard Terms and Contracting Provisions in lieu of stipulating exceptions below.
- Making revisions to State statutes and regulations is prohibited.
- The State has no obligation to accept any exception(s).

# Department of Health and Human Resources

6.1 Exception #1 – <Insert Title of Provision>

| Document Title (Reference Specific Contractual Document and Section in Which Exception is Taken) | Vendor's Explanation (Required for Any Rejection/Exception) | Vendor's Proposed Alternative Language (If Applicable) Cross-Reference to specific section of Vendor's Terms, If Any Provided As Part of the RFP Response |
|---|---|---|
| N/A | N/A | N/A |
| NOTES/COMMENTS: <FOR STATE USE ONLY> | | |

6.2 Exception #2 – <Insert Title of Provision>

| Document Title (Reference Specific Contractual Document and Section in Which Exception is Taken) | Vendor's Explanation (Required for Any Rejection/Exception) | Vendor's Proposed Alternative Language (If Applicable) Cross-Reference to specific section of Vendor's Terms, If Any Provided As Part of the RFP Response |
|---|---|---|
| N/A | N/A | N/A |
| NOTES/COMMENTS: <FOR STATE USE ONLY> | | |

# Department of Health and Human Resources

## 6.8 Availability of Information

Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). Submission of any document to the State constitutes your explicit consent to the subsequent public disclosure of the document. The Purchasing Division will disclose, without redaction, any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to include any "trade secrets" as defined by West Virginia Code § 47-22-1 et seq. All other information associated with the RFP, including, but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d.

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health(R) of West Virginia
(Company)

Todd White, Chief Executive Officer
(Representative Name, Title)

304-348-2041/959-282-1026
(Contact Phone/Fax Number)

10/24/22
(Date)

## WV STATE GOVERNMENT

## HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

    a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.html.

    b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

    c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

    d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

    e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures.** Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. **Obligations of Associate.**

a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.

b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;

ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;

iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;

iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.

d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction**. Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. **Addendum Administration.**

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED:

Name of Agency: DNR/BMS

Signature: Cynthia Bruce

Title: Commissioner

Date: 1-25-23

Name of Associate: Aetna Better Health of WV

Signature:

Title: CEO

Date: 1-25-23

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY Of January 20 23
Patrick Morrisey
Attorney General
BY

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: AETNA Better Health of WV

Name of Agency: DHHR/BMS

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

Member and provider demographics and claims.

# FEDERAL FUNDS ADDENDUM

2 C.F.R. §§ 200.317 – 200.327

**Purpose:** This addendum is intended to modify the solicitation in an attempt to make the contract compliant with the requirements of 2 C.F.R. §§ 200.317 through 200.327 relating to the expenditure of certain federal funds. This solicitation will allow the State to obtain one or more contracts that satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

**Instructions:** Vendors who are willing to extend their contract to procurements with federal funds and the requirements that go along with doing so, should sign the attached document identified as: "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)"

Should the awarded vendor be unwilling to extend the contract to federal funds procurement, the State reserves the right to award additional contracts to vendors that can and are willing to meet federal funds procurement requirements.

**Changes to Specifications:** Vendors should consider this solicitation as containing two separate solicitations, one for state level procurement and one for county/local procurement.

**State Level:** In the first solicitation, bid responses will be evaluated with applicable preferences identified in sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" to establish a contract for both standard state procurements and state federal funds procurements.

**County Level:** In the second solicitation, bid responses will be evaluated with applicable preferences identified in Sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" omitted to establish a contract for County/Local federal funds procurement.

**Award:** If the two evaluations result in the same vendor being identified as the winning bidder, the two solicitations will be combined into a single contract award. If the evaluations result in a different bidder being identified as the winning bidder, multiple contracts may be awarded. The State reserves the right to award to multiple different entities should it be required to satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

**State Government Use Caution:** State agencies planning to utilize this contract for procurements subject to the above identified federal regulations should first consult with the federal agency providing the applicable funding to ensure the contract is complaint.

**County/Local Government Use Caution:** County and Local government entities planning to utilize this contract for procurements subject to the above identified federal regulation should first consult with the federal agency providing the applicable funding to ensure the contract is complaint. For purposes of County/Local government use, the solicitation resulting in this contract was conducted in accordance with the procurement laws, rules, and procedures governing the West Virginia Department of Administration, Purchasing Division, except that vendor preference has been omitted for County/Local use purposes and the contract terms contained in the document entitled "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)" have been added.

# FEDERAL FUNDS ADDENDUM

## REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

The State of West Virginia Department of Administration, Purchasing Division, and the Vendor awarded this Contract intend that this Contract be compliant with the requirements of the Procurement Standards contained in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements found in 2 C.F.R. § 200.317, et seq. for procurements conducted by a Non-Federal Entity. Accordingly, the Parties agree that the following provisions are included in the Contract.

1. **MINORITY BUSINESSES, WOMEN'S BUSINESS ENTERPRISES, AND LABOR SURPLUS AREA FIRMS:** (2 C.F.R. § 200.321)

    a. The State confirms that it has taken all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible. Those affirmative steps include:

        (1) Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
        (2) Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;
        (3) Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;
        (4) Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises;
        (5) Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce; and
        (6) Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in paragraphs (1) through (5) above.

    b. Vendor confirms that if it utilizes subcontractors, it will take the same affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

2. **DOMESTIC PREFERENCES:** (2 C.F.R. § 200.322)

    a. The State confirms that as appropriate and to the extent consistent with law, it has, to the greatest extent practicable under a Federal award, provided a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United

States (including but not limited to iron, aluminum, steel, cement, and other manufactured products).

b. Vendor confirms that will include the requirements of this Section 2. Domestic Preference in all subawards including all contracts and purchase orders for work or products under this award.

c. Definitions: For purposes of this section:

(1) "Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.
(2) "Manufactured products" means items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

3. **BREACH OF CONTRACT REMEDIES AND PENALTIES:**
(2 C.F.R. § 200.327 and Appendix II)

(a) The provisions of West Virginia Code of State Rules § 148-1-5 provide for breach of contract remedies, and penalties. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

4. **TERMINATION FOR CAUSE AND CONVENIENCE:**
(2 C.F.R. § 200.327 and Appendix II)

(a) The provisions of West Virginia Code of State Rules § 148-1-5 govern Contract termination. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

5. **EQUAL EMPLOYMENT OPPORTUNITY:**
(2 C.F.R. § 200.327 and Appendix II)

Except as otherwise provided under 41 CFR Part 60, and if this contract meets the definition of "federally assisted construction contract" in 41 CFR Part 60–1.3, this contract includes the equal opportunity clause provided under 41 CFR 60–1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964–1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

6. **DAVIS-BACON WAGE RATES:**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this Contract includes construction, all construction work in excess of $2,000 will be completed and paid for in compliance with the Davis–Bacon Act (40 U.S.C. 3141–3144, and 3146–3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must:

(a) pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor.
(b) pay wages not less than once a week.

A copy of the current prevailing wage determination issued by the Department of Labor is attached hereto as Exhibit B. The decision to award a contract or subcontract is conditioned upon the acceptance of the wage determination. The State will report all suspected or reported violations to the Federal awarding agency.

7. **ANTI-KICKBACK ACT:**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that it will comply with the Copeland Anti-KickBack Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). Accordingly, Vendor, Subcontractors, and anyone performing under this contract are prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The State must report all suspected or reported violations to the Federal awarding agency.

8. **CONTRACT WORK HOURS AND SAFETY STANDARDS ACT**
(2 C.F.R. § 200.327 and Appendix II)

Where applicable, and only for contracts awarded by the State in excess of $100,000 that involve the employment of mechanics or laborers, Vendor agrees to comply with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, Vendor is required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

9. **RIGHTS TO INVENTIONS MADE UNDER A CONTRACT OR AGREEMENT.**
(2 C.F.R. § 200.327 and Appendix II)

If the Federal award meets the definition of "funding agreement" under 37 CFR § 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

10. **CLEAN AIR ACT**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this contract exceeds $150,000, Vendor is to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401–7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251–1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

11. **DEBARMENT AND SUSPENSION**
(2 C.F.R. § 200.327 and Appendix II)

The State will not award to any vendor that is listed on the governmentwide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

12. **BYRD ANTI–LOBBYING AMENDMENT**
(2 C.F.R. § 200.327 and Appendix II)

Vendors that apply or bid for an award exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non–Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non–Federal award.

13. **PROCUREMENT OF RECOVERED MATERIALS**
(2 C.F.R. § 200.327 and Appendix II; 2 C.F.R. § 200.323)

Vendor agrees that it and the State must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the

Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

14. **PROHIBITION ON CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT.**
(2 C.F.R. § 200.327 and Appendix II; 2 CFR § 200.216)

Vendor and State agree that both are prohibited from obligating or expending funds under this Contract to:

(1) Procure or obtain;
(2) Extend or renew a contract to procure or obtain; or
(3) Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115–232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

(i) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).
(ii) Telecommunications or video surveillance services provided by such entities or using such equipment.
(iii) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

In implementing the prohibition under Public Law 115–232, section 889, subsection (f), paragraph (1), heads of executive agencies administering loan, grant, or subsidy programs shall prioritize available funding and technical support to assist affected businesses, institutions and organizations as is reasonably necessary for those affected entities to transition from covered communications equipment and services, to procure replacement equipment and services, and to ensure that communications service to users and customers is sustained.

State of West Virginia

By: Robert Price

Printed Name: Robert Price

Title: Administrative Services Manger II

Date: 01/25/2023

Vendor Name:

By:

Printed Name: Todd R White

Title: CEO

Date: 1-25-23

EXHIBIT A To:
REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

W. Va. CSR § 148-1-5

West Virginia Code of State Rules
Title 148. Department of Administration
Legislative Rule (Ser. 1)
Series 1. Purchasing

W. Va. Code St. R. § 148-1-5

§ 148-1-5. Remedies.

Currentness

5.1. The Director may require that the spending unit attempt to resolve any issues that it may have with the vendor prior to pursuing a remedy contained herein. The spending unit must document any resolution efforts and provide copies of those documents to the Purchasing Division.

5.2. Contract Cancellation.

5.2.1. Cancellation. The Director may cancel a purchase or contract immediately under any one of the following conditions including, but not limited to:

5.2.1.a. The vendor agrees to the cancellation;

5.2.1.b. The vendor has obtained the contract by fraud, collusion, conspiracy, or is in conflict with any statutory or constitutional provision of the State of West Virginia;

5.2.1.c. Failure to honor any contractual term or condition or to honor standard commercial practices;

5.2.1.d. The existence of an organizational conflict of interest is identified;

5.2.1.e. Funds are not appropriated or an appropriation is discontinued by the legislature for the acquisition;

5.2.1.f. Violation of any federal, state, or local law, regulation, or ordinance, and

5.2.1.g. The contract was awarded in error.

5.2.2. The Director may cancel a purchase or contract for any reason or no reason, upon providing the vendor with 30 days' notice of the cancellation.

5.2.3. Opportunity to Cure. In the event that a vendor fails to honor any contractual term or condition, or violates any provision of federal, state, or local law, regulation, or ordinance, the Director may request that the vendor remedy the contract breach or legal violation within a time frame the Director determines to be appropriate. If the vendor fails to remedy the contract breach or legal violation or the Director determines, at his or her sole discretion, that such a request is unlikely to yield a satisfactory result, then he or she may cancel immediately without providing the vendor an opportunity to perform a remedy.

5.2.4. Re-Award. The Director may award the cancelled contract to the next lowest responsible bidder (or next highest scoring bidder if best value procurement) without a subsequent solicitation if the following conditions are met:

5.2.4.a. The next lowest responsible bidder (or next highest scoring bidder if best value procurement) is able to perform at the price contained in its original bid submission, and

5.2.4.b. The contract is an open-end contract, a one-time purchase contract, or a contract for work which has not yet commenced.

Award to the next lowest responsible bidder (or next highest scoring bidder if best value procurement) will not be an option if the vendor's failure has in any way increased or significantly changed the scope of the original contract. The vendor failing to honor contractual and legal obligations is responsible for any increase in cost the state incurs as a result of the re-award.

5.3. Non-Responsible. If the Director believes that a vendor may be non-responsible, the Director may request that a vendor or spending unit provide evidence that the vendor either does or does not have the capability to fully perform the contract requirements, and the integrity and reliability necessary to assure good faith performance. If the Director determines that the vendor is non-responsible, the Director shall reject that vendor's bid and shall not award the contract to that vendor. A determination of non-responsibility must be evaluated on a case-by-case basis and can only be made after the vendor in question has submitted a bid. A determination of non-responsibility will only extend to the contract for which the vendor has submitted a bid and does not operate as a bar against submitting future bids.

5.4. Suspension.

5.4.1. The Director may suspend, for a period not to exceed 1 year, the right of a vendor to bid on procurements issued by the Purchasing Division or any state spending unit under its authority if:

5.4.1.a. The vendor has submitted a bid and then requested that its bid be withdrawn after bids have been publicly opened.

5.4.1.b. The vendor has exhibited poor performance in fulfilling his or her contractual obligations to the State. Poor performance includes, but is not limited to any of the following: violations of law, regulation, or ordinance; failure to deliver timely; failure to deliver quantities ordered; poor performance reports; or failure to deliver commodities, services, or printing at the quality level required by the contract.

5.4.1.c. The vendor has breached a contract issued by the Purchasing Division or any state spending unit under its authority and refuses to remedy that breach.

5.4.1.d. The vendor's actions have given rise to one or more of the grounds for debarment listed in W. Va. Code § 5A-3-33d.

5.4.2. Vendor suspension for the reasons listed in section 5.4 above shall occur as follows:

5.4.2.a. Upon a determination by the Director that a suspension is warranted, the Director will serve a notice of suspension to the vendor.

5.4.2.b. A notice of suspension must inform the vendor:

5.4.2.b.1. Of the grounds for the suspension;

5.4.2.b.2. Of the duration of the suspension;

5.4.2.b.3. Of the right to request a hearing contesting the suspension;

5.4.2.b.4. That a request for a hearing must be served on the Director no later than 5 working days of the vendor's receipt of the notice of suspension;

5.4.2.b.5. That the vendor's failure to request a hearing no later than 5 working days of the receipt of the notice of suspension will be deemed a waiver of the right to a hearing and result in the automatic enforcement of the suspension without further notice or an opportunity to respond; and

5.4.2.b.6. That a request for a hearing must include an explanation of why the vendor believes the Director's asserted grounds for suspension do not apply and why the vendor should not be suspended.

5.4.2.c. A vendor's failure to serve a request for hearing on the Director no later than 5 working days of the vendor's receipt of the notice of suspension will be deemed a waiver of the right to a hearing and may result in the automatic enforcement of the suspension without further notice or an opportunity to respond.

5.4.2.d. A vendor who files a timely request for hearing but nevertheless fails to provide an explanation of why the asserted grounds for suspension are inapplicable or should not result in a suspension, may result in a denial of the vendor's hearing request.

5.4.2.e. Within 5 working days of receiving the vendor's request for a hearing, the Director will serve on the vendor a notice of hearing that includes the date, time and place of the hearing.

5.4.2.f. The hearing will be recorded and an official record prepared. Within 10 working days of the conclusion of the hearing, the Director will issue and serve on the vendor, a written decision either confirming or reversing the suspension.

5.4.3. A vendor may appeal a decision of the Director to the Secretary of the Department of Administration. The appeal must be in writing and served on the Secretary no later than 5 working days of receipt of the Director's decision.

5.4.4. The Secretary, or his or her designee, will schedule an appeal hearing and serve on the vendor, a notice of hearing that includes the date, time and place of the hearing. The appeal hearing will be recorded and an official record prepared. Within 10 working days of the conclusion of the appeal hearing, the Secretary will issue and serve on the vendor a written decision either confirming or reversing the suspension.

5.4.5. Any notice or service related to suspension actions or proceedings must be provided by certified mail, return receipt requested.

5.5. Vendor Debarment. The Director may debar a vendor on the basis of one or more of the grounds for debarment contained in W. Va. Code § 5A-3-33d or if the vendor has been declared ineligible to participate in procurement related activities under federal laws and regulation.

5.5.1. Debarment proceedings shall be conducted in accordance with W. Va. Code § 5A-3-33e and these rules. A vendor that has received notice of the proposed debarment by certified mail, return receipt requested, must respond to the proposed debarment within 30 working days after receipt of notice or the debarment will be instituted without further notice. A vendor is deemed to have received notice, notwithstanding the vendor's failure to accept the certified mail, if the letter is addressed to the vendor at its last known address. After considering the matter and reaching a decision, the Director shall notify the vendor of his or her decision by certified mail, return receipt requested.

5.5.2. Any vendor, other than a vendor prohibited from participating in federal procurement, undergoing debarment proceedings is permitted to continue participating in the state's procurement process until a final debarment decision has been reached. Any contract that a debarred vendor obtains prior to a final debarment decision shall remain in effect for the current term, but may not be extended or renewed. Notwithstanding the foregoing, the Director may cancel a contract held by a debarred vendor if the Director determines, in his or her sole discretion, that doing so is in the best interest of the State. A vendor prohibited from participating in federal procurement will not be permitted to participate in the state's procurement process during debarment proceedings.

5.5.3. If the Director's final debarment decision is that debarment is warranted and notice of the final debarment decision is mailed, the Purchasing Division shall reject any bid submitted by the debarred vendor, including any bid submitted prior to the final debarment decision if that bid has not yet been accepted and a contract consummated.

5.5.4. Pursuant to W.Va. Code § 5A-3-33e(e), the length of the debarment period will be specified in the debarment decision and will be for a period of time that the Director finds necessary and proper to protect the public from an irresponsible vendor.

5.5.5. List of Debarred Vendors. The Director shall maintain and publicly post a list of debarred vendors on the Purchasing Division's website.

5.5.6. Related Party Debarment. The Director may pursue debarment of a related party at the

same time that debarment of the original vendor is proceeding or at any time thereafter that the Director determines a related party debarment is warranted. Any entity that fails to provide the Director with full, complete, and accurate information requested by the Director to determine related party status will be presumed to be a related party subject to debarment.

5.6. Damages.

5.6.1. A vendor who fails to perform as required under a contract shall be liable for actual damages and costs incurred by the state.

5.6.2. If any commodities delivered under a contract have been used or consumed by a spending unit and on testing the commodities are found not to comply with specifications, no payment may be approved by the Spending Unit for the merchandise until the amount of actual damages incurred has been determined.

5.6.3. The Spending Unit shall seek to collect damages by following the procedures established by the Office of the Attorney General for the collection of delinquent obligations.

**Credits**

History: Filed 4-1-19, eff. 4-1-19; Filed 4-16-21, eff. 5-1-21.

Current through register dated May 7, 2021. Some sections may be more current. See credits for details.
W. Va. C.S.R. § 148-1-5, WV ADC § 148-1-5

**End of Document**

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EXHIBIT B To:
REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

Prevailing Wage Determination

[ ] – Not Applicable Because Contract Not for Construction

[ ] – Federal Prevailing Wage Determination on Next Page

# COST PROPOSAL SUPPLEMENTAL INFORMATION

**Per Attachment A,**
**"The Vendor's response should provide sufficient information to allow the Department to assess the reasonableness of the Vendor's cost for the project as detailed in the Cost Workbook".**

Below is the supplemental information supporting Aetna Better Health of West Virginia ("Aetna")'s cost proposal as provided in Table I of Attachment A: Cost Proposal.

## Vendor's Bid Amount for Administrative Services (SNS)

After consideration of the requirements to provide Statewide administrative services for all individuals accessing Socially Necessary Services (SNS), Aetna Better Health of West Virginia will continue to provide SNS administration services under a sub-contractor arrangement with Keystone Peer Review Organization (Kepro). The ASO cost submitted for the administration of SNS services was based upon the rates negotiated with the subcontractor to ensure compliance with all contractual and RFP requirements and the payroll and related costs for key staff mandated in the RFP.

- A monthly bid rate of $89,117.52 with a 12-month total bid of $1,069,410.24.

1. Vendor's Bid Amount for Administrative Services (SNS) - Optional Year 1

- A monthly bid rate of $91,628.99 with a 12-month total bid of $1,099,547.88.

2. Vendor's Bid Amount for Administrative Services (SNS) - Optional Year 2

- A monthly bid rate of $93,930.09 with a 12-month total bid of $1,127,161.08.

3. Vendor's Bid Amount for Administrative Services (SNS) - Optional Year 3

- A monthly bid rate of $96,290.25 with a 12-month total bid of $1,155,483.00.

– Total contract Value is **$4,451,602.20**

## Attachment A: Cost Proposal

| *West Virginia Department of Health and Human Resources - Mountain Health Promise (MHP) Request for Proposal (RFP)* |
|---|
| Instructions: |
| **Vendor: *Aetna Better Health of*** |
| Vendors will be paid an **actuarially sound/certified** capitated per member per month (PMPM) rate set by the State for Managed Care Organization (MCO) physical and behavioral health services, which shall be firm and fixed for the period of the contract, subject to any adjustments warranted for modifications including, but not limited to, State or federal regulation, waiver amendments, required actuarial adjustments, and State Plan amendments. **Therefore, vendors will only be scored on administrative costs relative to Socially Needed Services (SNS) under the cost proposal.**<br><br>Vendors will be paid a fixed monthly amount for Administrative Services Organization (ASO) **administration** of SNS, which shall be firm and fixed for each contract year, subject to any adjustments warranted for modifications including, but not limited to, State or federal regulation, waiver amendments, and State Plan amendments. The vendor shall submit a desired, fixed monthly cost for SNS administration in rows 7 through 10. Rows 7 through 10 will automatically be multiplied by 12 and the total cost for each year will be displayed in cells D7-D10. Cell D11 will be automatically added to display a **Total Cost Proposal**<br><br>NOTE: The Vendor's bid amount entered into for the ASO SNS Services cost **should not** include any services costs for the SNS services themselves, and should **not** include any direct costs for medical expense. The bid amount is for ASO SNS **administration costs only**. Reimbursement for the SNS services provided to members will be reimbursed directly to the provider on a fee for service basis from Title IV funds. Reimbursement for MHP medical costs (physical/behavioral health) will be based on a actuarially sound/certified capitated rate basis, and those expenses/costs are not to be considered here as part of the SNS administrative costs. |

Table 1: Costs by Contract Item

| Contract Item | Bid Amount | Contract Months | Total Administrative Services Cost |
|---|---|---|---|
| **Vendor's Bid Amount for Administrative Services (SNS) - Year 1** | $ 89,117.52 | 12 | $ 1,069,410.24 |
| **Vendor's Bid Amount for Administrative Services (SNS) - Optional Year 1** | $ 91,628.99 | 12 | $ 1,099,547.88 |
| **Vendor's Bid Amount for Administrative Services (SNS) - Optional Year 2** | $ 93,930.09 | 12 | $ 1,127,161.08 |
| **Vendor's Bid Amount for Administrative Services (SNS) - Optional Year 3** | $ 96,290.25 | 12 | $ 1,155,483.00 |
| | | **Total Cost Proposal:** | $ 4,451,602.20 |

| RFP Table 1: Estimated Number of Individuals Who Access SNS | |
|---|---|
| Population | Estimated Enrollment |
| Eligible Youth (Calendar Year 2021) | 12,736 |