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: 09-25-2024

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 3
Document Name:	SPECIALIZED MANAGED CARE FOR CHILDREN AND YOUTH
Document Description:	SPECIALIZED MANAGED CARE FOR CHILDREN AND YOUTH
Procurement Type:	Central Master Agreement
Buyer Name:	
Telephone:	
Email:	
Shipping Method:	Best Way
Free on Board:	FOB Dest, Freight Prepaid

Procurement Folder:	1052601
Reason for Modification:	Change Order 02 To Renew Contract
Effective Start Date:	2023-07-01
Effective End Date:	2025-06-30

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: Lakendra R Burdette
Requestor Phone: (304) 352-4319
Requestor Email: lakendra.burdette@wv.gov

2025
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

9-25-24 GC

Purchasing Division's File Copy

Total Order Amount: Open End

CH 9/25/24

PURCHASING DIVISION AUTHORIZATION
DATE: Tara Lyons 9/25/24
ELECTRONIC SIGNATURE ON FILE

ATTORNEY GENERAL APPROVAL AS TO FORM
DATE: John S. Gray
ELECTRONIC SIGNATURE ON FILE

ENCUMBRANCE CERTIFICATION
DATE: 10-2-24
ELECTRONIC SIGNATURE ON FILE

10/2/2024

Extended Description:
Change Order

Change Order No. 2 is issued to renew the original contract according to all terms, conditions, prices and specifications contained in the original contract including authorized change orders.

Effective date of renewal 07/01/2024 through 06/30/2025.

Renewal Years Remaining: 2

No other changes.

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

Line	Commodity Code	Manufacturer	Model No	Unit	Unit Price
2	84131602				0.000000
	Service From	**Service To**		**Service Contract Amount**	
	2024-07-01	2025-06-30		1099547.88	

Commodity Line Description: Vendor's Bid Amount for Administrative Services (SNS) Year 2

Extended Description:
Vendor's Bid Amount for Administrative Services (SNS) Year 2

Todd R. White
Chief Executive Officer

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

304-348-2041 T
959-282-1026 F

June 17, 2024

Susan Deel, Chief, Center of Managed Care
WV Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
E-mail: susan.l.deel@wv.gov

RE: SFY2025 Purchase of Service Provider Agreement for Mountain Health Promise
Order No. CMA BMS 23*03

Dear Mrs. Deel:

This letter serves as the written acceptance by Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia of the terms and rates set forth in the attached *State Fiscal Year 2025 Purchase of Service Provider Agreement Between the State of West Virginia Department of Health and Human Resources Bureau for Medical Services and Coventry Health Care Inc., d/b/a Aetna Better Health of West Virginia* pertaining to Mountain Health Promise program.

Todd R. White
Chief Executive Officer

TRW/ago

Ok - Agree to renew 7/1/24-6/30/25
Althea Greenhowe

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**

Ok
Althea Greenhowe

STATE FISCAL YEAR 2024

MODEL PURCHASE OF SERVICE PROVIDER AGREEMENT FOR MOUNTAIN HEALTH PROMISE

BETWEEN

STATE OF WEST VIRGINIA

DEPARTMENT OF HUMAN SERVICES

BUREAU FOR MEDICAL SERVICES

BUREAU FOR SOCIAL SERVICES

AND

Aetna Better Health of West Virginia

SFY25 AMENDMENT
June 2024

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STATE OF WEST VIRGINIA

DEPARTMENT OF HUMAN SERVICES

BUREAU FOR MEDICAL SERVICES

PURCHASE OF SERVICE CONTRACT

ARTICLE I: STANDARD WEST VIRGINIA TERMS

This CONTRACT is made and entered into by and between the STATE OF WEST VIRGINIA, DEPARTMENT OF HUMAN SERVICES (DoHS), BUREAU FOR MEDICAL SERVICES (BMS), hereinafter referred to as the "Department," and Aetna Better Health of West Virginia, hereinafter referred to as the "Managed Care Organization (MCO)."

WHEREAS, the Department has conducted an open solicitation for the services of an MCO interested in entering into a Contract to provide risk-based comprehensive health services, children's residential care services, and Socially Necessary Services (SNS) administration to select West Virginia Medicaid managed care enrollees who are in foster care, are receiving adoption assistance, are children eligible under the Serious Emotional Disorder (CSED) Home and Community Based Services (HCBS) waiver program, or are youth formerly in foster care up to age twenty-six (26) who aged out of foster care while enrolled in Medicaid in the state of West Virginia; and

WHEREAS, the MCO has demonstrated the ability to provide risk-based comprehensive health services in compliance with the program terms and requirements; and

WHEREAS, the Department has approved the MCO to provide risk-based comprehensive health services, children's residential care services, and SNS to select West Virginia Medicaid managed care enrollees who are in foster care, are receiving adoption assistance, or are youth formerly in foster care up to age twenty-six (26) who aged out of foster care while enrolled in Medicaid in the state of West Virginia; and

WHEREAS, the Department has approved the MCO to provide risk-based comprehensive health services, and Medicaid HCBS waiver to select West Virginia Medicaid managed care enrollees who are eligible and enrolled through the Department's CSED waiver;
and

WHEREAS, the MCO must serve as an Administrative Services Organization (ASO) for the administration of SNS and has demonstrated the ability to oversee the utilization management of such services and oversight of the providers that administer them; and

NOW THEREFORE, in consideration of the foregoing recitals and of the mutual covenants contained herein, the Department and the MCO hereby agree as follows.

Notwithstanding the foregoing, the State of West Virginia, DOA Purchasing Division approval is not required on the Department's delegated or exempt purchases.

3. ENTIRE AGREEMENT

This Contract (including all provisions incorporated by reference in Article I, Section 1 and any appendices, exhibits, rate matrices and schedules hereto) constitutes the entire agreement between the parties. No amendment or other modification changing this Contract will have any force or effect unless it is in writing and duly executed by the parties. Said modification will be incorporated as a written amendment to the Contract.

4. CONTRACT ADMINISTRATION

This Contract will be administered for the State by the Department. The Assistant to the Deputy Secretary will serve as Contracting Officer upon the execution of the Contract. The Contracting Officer will be the primary contact for all matters related to this Contract.

5. NOTICES

Any notice required under this Contract must be deemed sufficiently given upon delivery, if delivered by hand (signed receipt obtained) or three (3) days after posting if properly addressed and sent certified mail return receipt requested. Notices must be addressed as follows:

Susan Deel, Director
Office of Managed Care
Bureau for Medical Services
West Virginia Department of Human Services
350 Capitol Street, Rm 251
Charleston, WV 25301
304-356-4073 (office phone)
Susan.H.Deel@wv.gov

Said notices will become effective on the date of receipt or the date specified within the notice, whichever comes later. Either party will be notified of an address change in writing.

All questions, requests, and other matters related to the administration of this Contract must be addressed to Susan Deel.

to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

Agency for Healthcare Research and Quality (AHRQ) – the lead Federal agency charged with improving the safety and quality of America's health care system. AHRQ develops the knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions.

Appeal – a request for a review of the MCO's adverse benefit determination as defined in this Contract and 42 CFR §438.400(b) (1-7).

Application Programming Interface (API) – permit retrieval of data through the use of common technologies and without special effort from the enrollee. Technical requirements, documentation, and access determinations for the APIs are as described in 42 CFR §§431.60 and 431.70.

Authorized Agent – any corporation, company, organization, or person or their affiliates, not in competition with the MCO for the provision of managed care services, retained by the Department to provide assistance with administering its MCO program or any other matter.

Authorized Representative – a person authorized by the enrollee in writing to make health-related decisions on behalf of an enrollee, including, but not limited to Enrollment and Disenrollment decisions, filing Appeals and Grievances with the Contractor, and choice of a Primary Care Physician (PCP). The Authorized Representative is the Parent, Adoptive Parent or legal guardian for a child. For an adult, this person is the legal guardian (guardianship action), health care power of attorney, other person that has power of attorney, or another signed HIPAA compliant document indicating who can make decisions on behalf of the enrollee. For Foster Care enrollees, the Authorized Representative is the child's Child Protective Services (CPS) worker at the Bureau for Social Services (BSS).

Behavioral Health Services – services used to treat a mental illness, behavioral disorder and/or substance use disorder (SUD) which necessitates therapeutic and/or supportive treatment, such services include but not limited to psychological and psychiatric services.

Bureau for Medical Services (BMS) – a division within the West Virginia the Department that serves as is the designated single state agency responsible for the administration of the State's Medicaid program and providing access to appropriate health care for Medicaid-eligible individuals.

Bureau for Public Health (BPH) – a division within the West Virginia the Department of Health that directs public health activities at all levels within the state to fulfill the core functions of public health: the assessment of community health status and available resources; policy development resulting in proposals to support and encourage better health; and assurance that needed services are available, accessible, and of acceptable quality.

Bureau for Social Services (BSS) – a division within the West Virginia the Department responsible for the operation of a number of programs that affect families and children, including day care centers, adult care providers, early childhood services and the fostering and adoption of

- Management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and
- Development and deployment of population health programs.

Case Management – a person-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote Quality cost-effective outcomes. Case Management serves as a means for achieving enrollee wellness and autonomy through advocacy, communication, education, and identification of services and resources. Interventions are undertaken with the purpose of helping enrollees receive appropriate care. Case Management is distinguished from Utilization Management in that it is voluntary and it is distinguished from Disease Management by its intensity and focus on any disease(s) or condition(s) of the enrollee.

Centers for Medicare & Medicaid Services (CMS) – a division within the federal Department of Health and Human Services (DHHS) responsible for the oversight of the Medicare program, the federal portion of the Medicaid program and Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, and related quality assurance activities.

Child Abuse – The Federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. § 5106g), as amended by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at minimum:

- "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation"; or
- "An act or failure to act which presents an imminent risk of serious harm."

Child Protective Services (CPS) Worker – a professional social worker who provides assistance to children and families by helping them address psychological and social problems related to child abuse and neglect. CPS Workers provide interventions, prepare treatment plans and case plans, and perform duties related to various social services program areas such as CPS, Foster Care, and Adoption Assistance.

Children and Youth with Special Health Care Needs (CYSHCN) – those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children's Bureau (CB) – the ACF office providing federal oversight for child welfare; focusing on improving the lives of children and families through programs that reduce child abuse and neglect, increase the number of adoptions, and strengthen foster care.

Children with Serious Emotional Disturbance (CSED) Waiver – a Medicaid home and community-based services waiver authorized under §1915(c) of the Social Security Act. The CSED waiver provides additional services to those provided through the Medicaid State Plan to children from three (3) up to age twenty-one (21) with an SED. It allows the State to provide an

Covered Services (Contract Services) – health care services the MCO must arrange to provide to Medicaid enrollees, including all services required by this Contract and state and federal law, and all Value-Added Services negotiated by the MCO and the Department.

Critical Incident – critical incidents are serious in nature and pose immediate risk to the health, safety, or welfare of the member or others. These incidents require in-depth investigation, an expedited timeline, and possibly additional resources.

Day – except where the term "business days" is expressly used, all references in this Contract will be construed as calendar days.

Default Enrollment (Assignment) – a process established by the Department through the CMS waiver authority to assign an enrollee who has not selected an MCO to an MCO.

Department – the West Virginia Department of Human Services (DoHS).

Department of Administration (DOA) Purchasing Division – the West Virginia agency responsible for the timely, responsive, and efficient procurement of goods and services for state government.

Department of Health and Human Services (DHHS) – the federal department dedicated to enhancing and protecting the health and well-being of all Americans by providing for effective health and human services and fostering advances in medicine, public health, and social services. It oversees CMS\and ACF federal agencies.

Direct Mail Marketing – any materials sent to potential enrollees by the MCOs or their agents through U.S. mail or any other direct or indirect delivery method.

Disability – a physical or mental impairment that substantially limits one (1) or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Disabled Person or Person with Disability – a person under sixty-five (65) years of age, including a child, who qualifies for Medicaid services because of a disability.

Durable Medical Equipment (DME) – certain medical equipment or supplies a provider orders for an enrollee's use such as wheelchairs, crutches, diabetic supplies, hospital beds, oxygen equipment and supplies, nebulizers, and walkers.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – Medically Necessary services, including interperiodic and periodic screenings, listed in Section 1905(a) of the Social Security Act. EPSDT entitles Medicaid-eligible infants, children, and other Medicaid enrollees under age twenty-one (21) to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act if that treatment

Encounter Data – procedure-level data on each contact between an enrolled individual and the health care system for a health care service or set of services included in the covered services under the Contract.

Enrollee – a recipient/enrollee who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the MCO enrollment information which the Department will transmit to the MCO every month in accordance with an established notification schedule. An enrollee may also refer to an individual who has been deemed eligible for Medicaid, but not yet enrolled with a specific MCO.

Enrollment Broker – the entity contracted by the Department to conduct outreach and enrollment of eligible West Virginia Medicaid managed care enrollees. The enrollment broker is not applicable under this contract as a single MCO contract.

Excluded Services – health care services that the MCO does not pay for or cover.

External Quality Review (EQR) – the analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on quality, timeliness, and access to the health care services that the MCO or its Subcontractors furnish to Medicaid beneficiaries.

External Quality Review Organization (EQRO) – the entity contracted by the Department to conduct periodic independent studies regarding the quality of care delivered to West Virginia Medicaid managed care enrollees. EQRO must meet the competence and independence requirements set forth in 42 CFR §438.354, and perform external quality review, other EQR-related activities as set forth in 42 CFR §438.358, or both.

Family First Prevention Services Act (FFPSA) – the law that reforms Title IV-E and Title IV-B of the Social Security Act and federal child welfare financing providing services to families at risk of entering the child welfare system.

Family Planning Services – those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These services include: health education and counseling necessary to make informed choices and understand contraceptive methods; limited history and physical examination; laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods; diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated; screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment; follow-up care for complications associated with contraceptive methods issued by the family planning provider; provision of contraceptive pills /devices/supplies; tubal ligation; vasectomies; and pregnancy testing and counseling.

Family Service Plan (FSP) – a plan developed for and in consultation with the family to document the strategy to reduce the risk, needs, and contributing influences which require Youth Services intervention.

Fictive Kin – In accordance with WV Code §49-1-206, an adult of at least twenty-one (21) years of age who is not a relative of the child, but who has an established, substantial relationship with the child, including but not limited to teachers, coaches, ministers, parents of family members of

Habilitation Services and Devices – health care services and devices that help an individual keep, learn, or improve skills and functioning for daily living such as occupational therapy, speech therapy, and other services for people with disabilities in inpatient and/ or outpatient settings.

Health Assessment – a process involving systematic collection and analysis of health-related information on patients for use by patients, clinicians, and health care teams to identify and support beneficial health behaviors and mutually work to direct changes in potentially harmful health behaviors. Health assessments are not intended to be diagnostic tools and they are not complete health histories; instead, they aim to be one method to engage patients in their own health, leading to better health choices and improved health behaviors in the long term.

Health Education – programs, services, promotions, and materials designed or intended to help the MCO's existing or potential enrollees to improve their health by increasing knowledge, influencing motivation and improving health literacy. Appendix C specifies additional detail about health education materials.

Health Home – a designated provider (including provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual to provide health home services as defined in Section 1945 of the Social Security Act. Chronic condition health homes are available for eligible individuals with certain chronic conditions. West Virginia's requirements for health homes are defined in the Medicaid State Plan.

Health Information Systems Strategy – written strategy that addresses potential risks, mitigation strategies, and timelines for implementing new information systems and changes to the MCO's existing systems.

Health Insurance – a contract that requires an MCO to pay some or all of an enrollee's healthcare costs in exchange for a premium.

Health Plan – another term used to refer to an MCO. Also referred to as a Plan.

Home and Community Based Services (HCBS) – services provided in the individual's home or community to targeted population groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses and provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings.

Home Health Care – health care services a person receives at home, including limited part-time or intermittent skilled nursing care, home health aide services, occupational therapy, speech therapy, medical social services, DME, medical supplies, and other services.

Home Visitation Program – a program of BSS within the Office of Maternal, Child and Family Health that involves partnerships at federal, state and community levels to assist families in meeting their parenting goals. Programs are available at no cost to families across the state. Programs are delivered by local home visitors who have received extensive training in evidence-based curriculums. These in-home visits can be initiated during pregnancy and continue to age three to five. Using a family-centered, asset-building approach, families determine what issues

Managing Employee – a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency, in accordance with 42 CFR §455.101.

Marketing – any communication, from the MCO to a Medicaid-eligible person who is not enrolled in the MCO, that can reasonably be interpreted as intended to influence such person to enroll in that particular MCO's Medicaid program, or either to not enroll in, or to disenroll from, another MCO's Medicaid program. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR §155.20, about the qualified health plan.

Marketing Materials – materials that are produced in any medium, by or on behalf of an MCO, and can reasonably be interpreted as intended to market an MCO to potential enrollees.

MCO Readiness Review – the assurances made by a selected MCO and the examination conducted by the Department, or its agents, of MCO's ability, preparedness, and availability to fulfill its obligations under this Contract, State Plan, and federal waiver.

MCO Service Area – all the counties included in any Department's defined service area. The MCO is contracted to operate statewide.

Medicaid – the West Virginia Medical Assistance Program operated and funded by the Department pursuant to Title XIX, Social Security Act (42 U.S.C. §1396 et seq.), and related State and Federal rules and regulations (same as Medical Assistance).

Medicaid Management Information System (MMIS) – an integrated group of subsystems used for the processing, collecting, analysis, and reporting of information needed to support Medicaid and Children's Health Insurance Program (CHIP) functions including claims and payments.

Medicaid Policy – collectively refers to documents and other written materials including the State Medicaid plan, program instructions, attendant provider manuals, program bulletins, and all published policy decisions issued by BMS. These materials are available through BMS.

Medicaid Program Provider Manuals – service-specific documents created by the Bureau for Medical Services to describe policies and procedures applicable to the program generally and that service specifically.

Medical Assessment – an initial medical evaluation completed for enrollees in Foster Care when they have newly entered or are re-entering Foster Care. The Medical Assessment must follow the requirements set forth in Medicaid EPSDT program, and include dental, hearing, and developmental screenings. A trauma assessment must also be performed at this time. Assessments must be completed within thirty (30) calendar days.

Medical Loss Ratio (MLR) – the ratio of the numerator (as defined in accordance with 42 CFR §438.8(e)) to the denominator (as defined in accordance with 42 CFR §438.8(f)) and subject to any applicable adjustments, as provided under this Contract and Appendix G.

provided so that an enrollee with no other transportation resource can receive services from an entity providing Medicaid covered services. NEMT does not include transportation provided on an emergency basis.

Non-Participating Provider – a doctor, hospital, facility, or other licensed health care professional who has not signed a contract or had a contract signed on his/her behalf agreeing to provide services to the MCO's enrollees.

Open Panel – Primary Care Physicians (PCPs) who are accepting new patients for the MCO.

Overpayment – money paid to a Provider by an MCO for a claim or claims, which exceeds the amount which should have been paid by the MCO.

Participating Provider – a doctor, hospital, facility, or other licensed health care professional who has signed a contract or had a contract signed on his/her behalf agreeing to provide services to the MCO's enrollees.

Patient-Centered Medical Home – "a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include, but is not limited to, nurse practitioners (NP), nurses, physician assistants (PA), behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology. At the point in time that CMS includes the NP as a leader of the multidisciplinary health team, this state will automatically implement this change (§16-29 H-9 of the West Virginia State Code)."

Patient Protection and Affordable Care Act (PPACA) – the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA).

Periodicity Schedule – the requirements and frequency by which periodic screening services are provided and covered. Schedule must meet current standards of pediatric medical and dental practice and specify screening services applicable at each stage of the enrollee's life, beginning with a neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services.

Person Centered Service Planning Team (PCSPT) – a team formed when a member enrolled in the CSED waiver turns fifteen (15) and that is responsible for developing measurable outcomes that guide the member toward transition or graduation from waiver enrollment.

Persons with Special Health Care Needs (SHCN) – individuals who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that generally required by individuals in that age range.

Psychiatric Residential Treatment Facilities (PRTF) – a separate, standalone entity or a distinct part of the acute care general psychiatric hospital providing a range of comprehensive psychiatric services to treat the psychiatric condition of residents under age twenty-one (21) years on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident's condition or prevent further regression so that the services will no longer be needed. (42 CFR §483.352, subpart D of part 441).

Pulmonary Rehabilitation – individually tailored multidisciplinary approach to the rehabilitation of enrollees who have pulmonary disease.

Qualified Residential Treatment Program (QRTP) – a specific category of a licensed non-foster family home setting with a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the required thirty (30) day assessment of the appropriateness of the placement.

Regulation – a Federal or State agency statement of general applicability designed to implement or interpret law, policy, or procedure.

Rehabilitation Services and Devices – health care services and devices that help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because he was sick, hurt, or disabled including occupational therapy, speech therapy, and psychiatric rehabilitation services in inpatient and/ or outpatient settings.

Request for Proposals (RFP) – a document, containing the specifications or scope of work and all contractual terms and conditions, which is used to solicit written bids.

Residential Placement – an Out of Home Placement setting designed to meet the needs of children and youth with behavioral, emotional and mental health needs that prevent them from being able to reside in a less structured family home setting. A residential treatment facility offers a structured physical environment and a treatment program designed to help children improve their ability to function in multiple areas of life.

Risk – the possibility of monetary loss or gain by the MCO resulting from service costs exceeding or being less than payments made to it by the Department.

Routine Care – basic primary care services including the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need for more complex treatment.

Serious Emotional Disturbance (SED) – a diagnosable mental, behavioral, or emotional disorder at any time during the past year of sufficient duration to meet diagnostic criteria specified within the Diagnostic Statistical Manual (DSM) and that resulted in functional impairment which substantially interfered with or limited the child's role or functioning in family, school, or community activities.

widest array of options for meeting those needs. TCM is not a direct service. TCM is composed of a number of federally designated components: Needs assessment and Reassessment; Development and Revision of TCM Service Plan; Referral and Related Activities; and Monitoring and Follow-up.

Temporary Assistance to Needy Families (TANF) – the federally funded program that provides assistance to families with children who meet the categorical requirements for aid.

Tertiary Services – highly specialized medical services administered in a specialized medical facility.

Third Party – any individual entity or program which is or may be liable to pay all or part of the expenditures for Medicaid furnished under a State Plan.

Title XIX – refers to Title XIX of the Social Security Act codified at 42 United States Code Annotated Section 1396 et. seq., including any amendments thereto (see Medicaid).

Transgender Female – A person assigned a male sex at birth who identifies as female.

Transgender Male – A person assigned a female sex at birth who identifies as male.

Transition of Care – the movement of patients between health care practitioners and/or settings as their condition and care needs change during the course of a chronic or acute illness. For Foster Care enrollees, and Adoption Assistance enrollees, Transition of Care planning may involve activities or needs related to an enrollee's placement in BSS custody or, transition from Mountain Health Trust (MHT) Medicaid or commercial health plans to the Mountain Health Promise (MHP); changes in Residential Placement; aging out of Foster Care; or transitioning out of MHP to MHT or West Virginia Health Bridge (WVHB) Medicaid managed care or a commercial health plan.

Trauma Assessment – an in-depth exploration of the nature and severity of the traumatic events experienced directly or witnessed by the child, the sequence of those events, and the current trauma-related symptoms to determine the best type of treatment for that specific child. The provider must use a BSS approved assessment tool to identify the types and severity of symptoms the child is experiencing. The comprehensive Trauma Assessment must provide recommendations to coordinate services and meet the child's needs.

Trauma Assessment Screening – a tool used by providers to ascertain an individual's trauma history and trauma related symptoms. This information can help identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress and inform treatment options.

Urgent Care – refers to circumstances in which the individual requires prompt medical attention for the care and management of a significant physical or mental disorder, but there is no immediate threat to the individual's life.

contract. For SNS, the MCO shall have administrative responsibilities for all enrollees eligible for services, independent of their enrollment status with the MCO for Medicaid-covered services.

4.4 Voluntary and Involuntary Disenrollment

All MCO enrollees will remain continuously enrolled throughout the term of this Contract, except in situations where clients lose their Medicaid eligibility, are admitted to a skilled nursing facility (SNF) or nursing facility, voluntarily disenroll, or are re-categorized into a Medicaid coverage category not included in the managed care delivery system. The Department will notify the MCO of all disenrollment, by means of a monthly enrollment roster report which explicitly identifies terminations from enrollment and the cause of the disenrollment (e.g., loss of Medicaid eligibility, change in eligibility status to a coverage code not included in the managed care initiative, voluntary switching to FFS or other causes).

4.5 Capitation Payments to Managed Care Organization

Payment to the MCO will be based on the enrollment data transmitted from the Department's eligibility vendor to its Fiscal Agent each month for MCO-eligible members.

The MCO must notify BMS in writing of any inconsistency between enrollment and payment data no later than within forty-five (45) calendar days from the day inconsistency was determined by the MCO. BMS agrees to provide to the MCO information needed to determine the source of the inconsistency within ten (10) business days after receiving written notice of the request to furnish such information. BMS will recoup overpayments or reimburse underpayments as soon as administratively possible. The adjusted payment (representing reinstated enrollees) for each month of coverage will be included in the next monthly capitation payment, based on updated MCO enrollment information for that month of coverage.

Any retrospective adjustments to prior capitations will be made in the form of an addition to or subtraction from the current month's capitation payment. Positive adjustments are particularly likely for newborns, where the MCO may be aware of the birth before BMS.

In full consideration of Contract services rendered by the MCO, the Department agrees to pay the MCO monthly payments based on the methodology specified in Appendix B. Department capitation payments to the MCO will apply to the time period July 1, 2023, through June 30, 2024 (State Fiscal Year 2024). The MCO assumes risk for the cost of services covered under this Contract and will incur loss if the cost of furnishing the services exceeds the payments under the Contract. The MCO must accept as payment in full, the amount paid by the Department.

No payment will be made for services furnished by a provider other than the MCO provider, if the services were available under the provider Contract unless otherwise authorized by the MCO except when these payments are specifically required to be made by the State in Title XIX of the Act, in 42 CFR chapter IV, or when the State agency makes direct payments to network providers for graduate medical education costs approved under the State plan.

Payments for medical services provided for under the Contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid (CMS). CMS may deny payment for new enrollees to the State if its determination is not timely contested by the MCO per 42 CFR §438.726(b) and §438.730.

The MCO must serve all enrollees for whom current payment has been made to the MCO without regard to disputes about enrollment status and without regard to any other identification requirements. If such person later is found to be inappropriately enrolled in the MCO, then the MCO will retain the capitation payment for that month and must provide services for that month. The Department will make every effort to ensure that only those individuals eligible for enrollment are enrolled in the MCO. In instances where enrollment is disputed between two (2) MCOs, the Department will be the final arbitrator of the MCO membership and reserves the right to recover an inappropriate capitation payment, including but not limited to untimely notice from the MCO to the Department of an enrollee's request to disenroll, when such requests are submitted to the MCO.

4.8 Information

The Department will notify the MCO in writing of any exclusion initiated by the Department for a FFS Medicaid or BSS provider so that the MCO can exclude that provider from its network.

4.9 Ongoing Managed Care Organization Monitoring

To ensure the quality of care, the Department will undertake monitoring activities outlined in 42 CFR §438.66 including, but not limited to:

1. Analyze the MCO's access enhancement programs, financial and utilization data, and other reports to monitor the value the MCO is providing in return for the State's capitation revenues. Such efforts will include audits of the MCO and its Subcontractors.
2. Conduct regular enrollee surveys addressing issues such as satisfaction and reasons for disenrollment.
3. Review MCO certifications on a regular basis.
4. At the Department's discretion, commission or conduct additional objective studies of the effectiveness of the MCO.
5. Monitor the enrollment and termination practices.
6. Assure the proper implementation of the required grievance procedures.
7. Conduct periodic reviews of the MCO provider credentialing process and network to ensure that providers excluded from Medicaid and BSS participation are excluded from the MCO provider network.

These monitoring activities will take place at least once per year. The state will also perform a readiness review at least three (3) months prior to implementing a managed care program or the addition of a new eligibility group. The Department or its contractors must provide to the MCO summaries, at the Department's expense, of all monitoring activity reports, surveys, audits, studies, reviews, and analyses.

The Department will submit to CMS a report on the managed care program no later than one hundred eighty (180) days after the end of each contract year and the report will be posted on the state's website and provided to the state's Medical Care Advisory Committee.

However, for each additional calendar day an item is overdue beyond the grace period, the Department may assess liquidated damages on the MCO as outlined in Article II, Section 6 and Appendix F.

5. DECLARATIONS AND MISCELLANEOUS PROVISIONS

5.1 Competition Not Restricted

In signing this Contract, the MCO asserts that no attempt has been made or can be made by the MCO to induce any other person or firm to submit or not to submit a proposal for the provision of services covered by this Agreement for the purpose of restricting competition.

5.2 Binding Authority

Each MCO representative signing the Contract must submit written certification along with the signed Contract that he/she is the person in the organization responsible for, or authorized to make, decisions regarding this Contract.

5.3 Nonsegregated Facilities

The MCO certifies that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not permit its employees to perform their services at any location, under its control, where segregated facilities are maintained. The MCO agrees that a breach of this certification is a violation of Equal Opportunity in Federal employment. In addition, the MCO must comply with the Federal Executive Order 11246 entitled "Equal Employment Opportunity" as amended by Executive Order 11375 and as supplemented in the United States Department of Labor Regulations (41 CFR Part 30). As used in this certification, the term "segregated facilities" includes any waiting rooms, restaurants and other eating areas, parking lots, drinking fountain, recreation or entertainment areas, transportation, and housing facilities provided for employees which are segregated on the basis of race, color, religion, or national origin, because of habit, local custom, national origin, or otherwise.

The organization further agrees (except where it has obtained identical certifications from proposed Subcontractors for specific time periods) that it will obtain identical certifications from proposed Subcontractors which are not exempt from the provisions for Equal Employment Opportunity; that it will retain such certifications in its files; and that it will forward a copy of this clause to such proposed Subcontractors (except where the proposed Subcontractors have submitted identical certifications for specific time periods).

5.4 Offer of Gratuities

The MCO warrants that it has not employed any company or person other than a bona fide employee working solely for the MCO or a company regularly employed as its marketing agent to solicit or secure the Contract and that it has not paid or agreed to pay any company or person any fee, commission, percentage, brokerage fee, gifts, or any other consideration contingent upon or resulting from the award of the Contract.

For breach or violation of this warranty, the Department will have the right to terminate this Contract with a thirty (30) calendar day notice without liability or, at its discretion to pursue any other remedies available under this Contract or by law.

5.9 Contract Liaison

Both parties agree to have specifically named Contract liaisons at all times. These representatives of the parties will be the first contacts regarding any questions and problems which arise during implementation and operation of the contract. Both parties agree to immediately notify the other party in writing should they appoint a Contract liaison other than the liaison named in this contract. The MCO's Contract liaison may also fulfill the duties of the Medicaid Administrator, as outlined in Article III, Section 5 of the contract.

5.10 Key Staff Positions

Key MCO personnel (e.g., owners, directors) must meet state law requirements for experience, licensure, and other ownership requirements. Where indicated in the below table, key staff must report solely to the West Virginia MHP Chief Executive Officer (CEO)/ Chief Operating Officer (COO) and all key staff must be dedicated full-time to supporting the West Virginia MHP contract unless otherwise approved by BMS. The MCO must receive approval from the Department to share positions across the MHT and MHP contracts.

The MCO must provide the Department with an organizational chart depicting the key staff positions in the Medicaid line of business by October 1st of each Contract year. The organizational chart must include the names, titles, and contact information for the key staff positions or functions identified below. For any BMS-approved deviations from the requirements for key staff, the MCO must submit supporting information with its organizational chart for the approval, including a description of the deviation, date of approval, and name of BMS approver. The deviation must be indicated in bold on the organizational chart.

Key Staff	
The below key staff report may report organizationally within the MCO's overall corporate structure.	
Chief Executive Officer (CEO)/Chief Operating Officer (CEO/COO)	Information Technology (IT) Director
The below key staff must report solely to the West Virginia MHP Chief Executive Officer (CEO)/ Chief Operating Officer (COO) unless otherwise approved by BMS.	
Contract Liaison/Medicaid Administrator	Social Services Director
Chief Financial Officer (CFO)	SNS Liaison
Medical Director	Quality Director
Medical Management (Utilization Review) Director	Enrollee Services Director
Care Management Director	Claims Payment Director
Behavioral Health Medical Director	Network Development Director

pharmacy management, medical management, care coordination, and issues related to the health, safety, and welfare of the member. The Administrator must ensure each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating services accessed by the enrollee, per 42 CFR § 438.208(b)(1).

The Administrator must have at least five (5) years' experience in Medicaid managed care contract oversight, substantial experience in healthcare, experience working with low-income populations, and cultural sensitivity, a Bachelor's degree or higher and be based in West Virginia.

3. The Chief Financial Officer (CFO) is responsible for oversight of all financial activities of the project. The CFO must: oversee the MCO's provider payment arrangements, including Alternative Payment Models (APMs); sign data certification forms, including, at a minimum, all encounter data and financial data and reporting for payments to contracted providers; and certify payment information to be utilized for rate setting purposes or any payment-related data required by the Department.

   The CFO must have at least five (5) years' experience serving as a financial lead for a managed care entity or other health insurance provider, a Bachelor's degree or higher and be based in West Virginia.

4. The Medical Director is responsible for oversight of medical and care coordination activities of the project. The Medical Director must attend in person, upon BMS request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. The Medical Director must respond to requests by the BMS Medical Director or Contract Administrator within three (3) business days, perform utilization management activities in collaboration with the Medical Management Director and Behavioral Health Medical Director and oversee or participate in the Quality Assurance and Performance Improvement (QAPI) Committee.

   The Medical Director must have at least five (5) years' experience in serving as Medical Director for a Medicaid program and five (5) years' experience working in pediatric care, an active West Virginia Medical License and availability to be on-site in West Virginia as requested by the Agency.

5. The Medical Management (Utilization Review) Director is responsible for oversight of utilization management activities of the project. The Director is responsible for the operations of the utilization management program, including oversight and management of processing referrals and pre-authorization requirements, as well as familiarity with appeal procedures. The Director must respond to requests from the BMS Medical Director or Contract Administrator within three (3) business days.

   The Director must have at least five (5) years' experience working as a utilization management manager or specialist for a Medicaid program, be a Registered Nurse (RN), Nurse Practitioner (NP), Physician's Assistant (PA), Licensed Professional Counselor (LPC), or Licensed Clinical Social Worker (LCSW) in West Virginia.

6. The Care Management (CM) Director is responsible for oversight of care management activities for the project. The CM Director oversees care management program operations, including, but not limited to, management and integration of care through the

The SNS Liaison must have at least five (5) years' experience working with SNS providers or as an MSW, LPC, or LCSW in lieu of experience and be based in West Virginia.

10. The Quality Director is responsible for oversight of the quality assurance program and related activities. The Director develops, administers, and oversees the quality assessment and performance improvement (QAPI) program, oversees and supports accreditation activities, such as NCQA, oversees or participates in the QAPI Committee, and initiates and maintains quality improvement projects that focus on one (1) or more quality indicators. The Director must develop an approach to monitoring provider performance, in collaboration with Network and Provider Relations Staff and engage in activities related to APMs as they relate to quality of care measures and performance indicators.

    The Director must have at least five (5) years' experience in overseeing a healthcare quality program, either with an MCO, an Administrative Services Organization (ASO), a state Medicaid agency, an external quality review organization (EQRO), a hospital, Psychiatric Residential Treatment Facility (PRTF), or long-term care facility. The Director must hold a Bachelor's degree or higher and/or be an RN and be based in West Virginia.

11. The Enrollee Services Director is responsible for oversight of activities related to call center operations, grievances, and other enrollee-related inquiries and matters. The Director oversees the Enrollee Services Department to assist enrollees in obtaining covered services, interfaces with enrollees, CPS workers, foster care parents, and providers to handle questions and complaints, ensures the enrollee services phone line meets he minimum performance requirements and oversees enrollment and onboarding activities of enrollees.

    The Director must have at least five (5) years' experience working with the public in an educational capacity on health insurance-related matters and experience working in or overseeing a call center.

12. The Claims Payment Director is responsible for oversight of all physical and behavioral health claims payment and encounters related activities. The Director shall ensure timely and accurate payment of provider claims for physical and behavioral health services, and in general monitor claims processing activities for these services, oversee the reprocessing of claims due to rate changes or claims resubmissions and oversee the submission and data integrity of encounter claims.

    The Director must have at least five (5) years' experience in a management capacity in claims processing and/or encounters with a health insurer.

13. The Network Development Director is responsible for network development and contracting activities for physical and behavioral health services. The Director establishes and maintains the provider network in geographically accessible locations for the population, ensures sufficient provider contracts for physical and behavioral health services to maintain access to care in accordance with BMS's Medicaid managed care network standards and develops and submits written documentation of the adequacy of the MCO's provider network as per contractual requirements. The Director facilitates physical health and behavioral health provider contracting activities, including creative

develops and submits all marketing materials to BMS. The Director must develop a written marketing plan, ensure prohibited marketing activities do not occur, engage with the community, and provide educational and informational materials at outreach events, in accordance with marketing activity regulations and guidelines.

The Director must have at least five (5) years' experience in working with the general public to better understand the healthcare environment and insurance and be based in West Virginia.

18. The Dental Director is responsible for oversight of administration of dental services within the contract. The Director performs oversight of utilization of covered dental services, performs dental utilization review decisions and is authorized to respond to dental clinical issues, utilization review, and dental quality of care inquiries.

    The Director must have at least five (5) years' experience in serving as a dental manager or director or provider serving Medicaid population and an active license to practice dentistry in West Virginia.

19. The Medicaid Enrollee Advocate is responsible for interacting with the population and ensures enrollees are referred and connected to appropriate resources. The Advocate must collaborate with the Care Management Director, care coordinators, and the SNS Liaison and provide enrollee support related to enrollment, access, and continuity of care issues. The Advocate must support enrollees throughout any grievances or appeals activities, assist enrollees in obtaining materials in alternative formats, as applicable, support and address needs of children and youth in foster care and interact with enrollees in a culturally sensitive manner.

    The Advocate must have at least five (5) years' experience in healthcare, working with low income and foster care populations, and cultural sensitivity and be based in West Virginia.

20. The CSED Director is responsible for oversight of the CSED Waiver portion of the MHP program. The Director shall collaborate with the Care Management Director, Medicaid Enrollee Advocate, care coordinators, and the SNS Liaison, provide support when CSED issues arise, and support and address needs of children with serious emotional disorders. The Director shall collaborate and interface with BSS and all CSED providers to facilitate enrollee access to care and positive health and social outcomes to maintain safety, permanency, and wellbeing and interacts with enrollees in a culturally sensitive manner.

    The Director must have at least five (5) years' experience working with children with serious emotional disorders, a Bachelor's degree or higher in a Human Services area and be based in West Virginia.

21. The Health Equity Director is responsible for leading the MCO's efforts to address health equity. The Director must lead development and implementation of initiatives to further health equity among membership. The Director must chair the MCO's Health Equity and Quality Committee and is responsible for oversight of reporting to BMS on status of initiatives and progress made.

    The Director must have at least three (3) years' experience in overseeing a Medicaid quality program with an MCO, a state Medicaid agency, or an EQRO. The Director must

- Chapter 9, Article 5 and Chapter 49, Articles 1, 2, and 4 of the West Virginia Code pertaining to the state's foster care program and transitioning the foster care population to an MCO (2019 WV House Bill 2010);
- Section 504 of the Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972;
- The Age Discrimination Act of 1975;
- Titles II and III of the Americans with Disabilities Act (ADA);
- Section 542 of the Public Health Service Act, pertaining to nondiscrimination against substance users;
- Title 45, Part 46 of the Code of Federal Regulations, pertaining to research involving human subjects;
- Title 45 Parts 160 and 164 Subparts A and E and Part 162, pertaining to privacy and confidentiality;
- Title 42 Parts 434 and 438 of the Code of Federal Regulations, pertaining to managed care;
- Title 42 Parts 438, 440, and 457 of the Code of Federal Regulations, pertaining to mental health parity and addiction equity;
- Copeland Anti-Kickback Act;
- Davis-Bacon Act;
- Contract Work Hours and Safety Standards;
- Right to Inventions Made Under a Contract or Agreement;
- Clean Air Act and Federal Water Pollution Control Act;
- Byrd Anti-Lobbying Amendment;
- Debarment and Suspension;
- American Disabilities Act of 1990 as amended;
- Assisted Suicide Funding Restriction Act of 1997;
- Patient Protection and Affordable Care Act (PPACA);
- Mental Health Parity and Addiction Equity Act of 2008;
- Family First Prevention Services Act (FFPSA) of 2018;
- Health Care and Education Reconciliation Act of 2010 (HCERA);
- Federal Information Security Management Act (FISMA); and
- Any other pertinent Federal, State, or local laws, regulations, or policies in the performance of this contract.

The MCO is prohibited from paying for an item or service with respect to any amount expended:

implementing regulations at 45 CFR Part 87 or 7 CFR Part 16; The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 et seq.). The MCO may not discriminate in enrollment, delivery of health care, or any other activity against enrollees on the basis of health status, conditions of or type of enrollment within the managed care initiative, or need for health care services.

The Department will deny payments for any new enrollees for whom payment is denied by CMS due to the MCO's discrimination of enrollees based on their health status or services sought.

5.16 Federal Requirements and Assurances

The MCO must comply with those federal requirements and assurances for enrollees of federal grants provided in the Office of Management and Budget Standard Form 424B which are applicable to the MCO. The MCO is responsible for determining which requirements and assurances are applicable to the MCO. Copies of the form are available from the Department.

The MCO must provide for the compliance of any Subcontractors with applicable federal requirements and assurances.

5.17 Lobbying

The MCO, as provided by 31 U.S.C. 1352 and 45 CFR §93.100 et seq., will not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

The MCO must submit to the Department a disclosure form as provided in 45 CFR §93.110, if any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with this contract.

The MCO must require that the language of this certification be included in the award documents for all sub-awards at all tiers (including Subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients must certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this Contract was made and entered into. Submission of this certification is a prerequisite for making and entering into this Contract imposed under Section 1352, Title 31, US Code. Any person who fails to file the required certification will be subject to a civil penalty.

5.18 Disclosure of Interlocking Relationships

If the MCO is not also a Federally-Qualified MCO under the Public Health Service Act, it must report to the State, and on request, to the Secretary, the Inspector General of the Department of Health and Human Services (DHHS), and the Comptroller General, a description of transactions between the MCO and parties in interest. Transactions that must be reported include: (1) any sale, exchange, or leasing of property; (2) any furnishing for consideration of goods, services, or

United States" and guidance provided by CMS under State Medicaid Director (SMD) letter #10-026.

All work performed by the MCO or a Subcontractor under this Contract must be performed exclusively within the United States with the exception of tasks that support the administration of the Medicaid State Plan as further described in this paragraph. No payments for items or services provided under the State Plan or under a waiver may be made by the MCO or a Subcontractor to any entity or financial institution outside of the United States. "Items or services provided under the State Plan or under a waiver" refers to medical assistance for which the State claims Federal funding under section 1903(a) of the Act. Tasks that support the administration of the Medicaid State Plan that may require payments to financial institutions or entities located outside of the U.S. are not prohibited under this statute (e.g., payments for outsourcing information processing related to plan administration or call centers related to enrollment or claims adjudication).

All information, including protected health information (PHI), obtained by the MCO or a Subcontractor under this Contract must be stored and maintained within the United States.

The term "within the United States" means any location inside the territorial boundaries comprising the United States of America, including any of the forty-eight (48) coterminous states in North America, the states of Alaska and Hawaii, and the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

5.23 Freedom of Information

Due regard will be given for the protection of proprietary information contained in all procurement-related documents received; however, the MCO should be aware that all materials associated with this agreement are subject to the terms of the Freedom of Information Act (FOIA), the Privacy Act and all rules, regulations, and interpretations resulting therefrom. It will not be sufficient for the MCO to merely state generally that the material is proprietary in nature and not therefore subject to release to third parties. Those particular pages of sections which MCO applicant believes to be proprietary must be specifically identified as such.

6. CONTRACT REMEDIES AND DISPUTES

6.1 MCO Performance

The MCO is expected to meet or exceed all the Department's objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by the Department. A designated representative of the MCO and a designated representative of the Department may meet as requested by either party, to review the performance of the MCO under this Contract. Written minutes of such meetings will be kept. In the event of any disagreement regarding the performance of services by the MCO under this Contract, the designated representatives must discuss the performance problem and negotiate in good faith in an effort to resolve the disagreement.

For purposes of this Contract, an item of non-compliance/non-performance means a specific action of the MCO or its Subcontractor, agent and/or consultant that:

- Violates a provision of this Contract including Appendices;
- Fails to meet an agreed measure of performance and/or standard; or

2. The Department may require a CAP to provide:
    a. Accelerated monitoring that includes more frequent or more extensive monitoring by the Department or its agent, including accelerated monitoring of any area in which the compliance is not fully met;
    b. Additional, more detailed, financial, and/or programmatic reports to be submitted by the MCO; and
    c. Additional and/or more detailed financial and/or programmatic audits or other reviews of the MCO.
3. The CAP must be submitted by the deadline set forth in the Department's request for a CAP. The CAP is subject to approval by the Department, which will not be unreasonably withheld.
4. The Department will notify the MCO in writing of its final disposition of the Department's concerns. If the Department accepts the MCO's proposed CAP, the Department may:
    a. Condition such approval on completion of tasks in the order or priority that the Department may reasonably prescribe;
    b. Disapprove portions of the MCO's proposed CAP;
    c. Require additional or different corrective action(s), not limited to the actions described in paragraph (2); or
    d. Notwithstanding the submission and acceptance of a CAP, MCO remains responsible for achieving all written performance criteria.
5. The Department's acceptance of a CAP under this Section will not:
    a. Excuse the MCO's prior non-performance;
    b. Relieve the MCO of its duty to comply with performance standards; or
    c. Prohibit the Department from assessing additional Contract remedies or pursuing other appropriate remedies for continued non-performance.

The Department retains authority to impose additional remedies under this Contract or state and federal statutes that address areas of non-performance. Nothing in this provision prevents the Department from exercising that authority.

6.3 Conditions Endangering Performance

At its option, the Department may provide the MCO with written notice of conditions endangering Contract performance. Conditions that endanger performance include, but are not limited to, the following:

- Failing to substantially provide Medically Necessary covered items and services that are required (under law or under the MCO's Contract with the Department) to be provided to an enrollee covered under the Contract;
- Failing to substantially provide covered SNS that are required (under law or under the MCO's Contract with the Department) to an enrollee covered under the Contract;

The Department is entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or Liquidated Damages resulting from the MCO's non-performance under this Contract. In some cases, the actual damage to the Department as a result of the MCO's failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract will be difficult or impossible to determine with precise accuracy. Therefore, in the event of non-performance under this Contract, the Department will impose, in writing, Liquidated Damages against the MCO. The Department will assess Liquidated Damages regardless of whether the non-performance is the fault of the MCO or the MCO's Subcontractors, agents and/or consultants, provided the Department has not materially caused or contributed to the non-performance. The Department will provide fifteen (15) days' notice of its intent to assess Liquidated Damages against the MCO. The MCO will have ten (10) days from receipt of the Letter of Intent to assess Liquidated Damages to appeal the sanction.

The Liquidated Damages prescribed in this Contract are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of the Department's projected financial loss and damage resulting from the MCO's non-performance. Accordingly, in the event the MCO fails to perform in accordance with the Contract, the Department may assess Liquidated Damages as provided in this section and in Appendix F of this Contract. Monetary damages imposed under this Contract will not exceed the amounts established under 42 CFR §438.704.

Any Liquidated Damages assessed by the Department will be due and payable within thirty (30) calendar days after the MCO's receipt of the notice of damages, regardless of any dispute in the amount or interpretation which led to the notice, or an appeal of the notice filed by the MCO. If MCO fails to pay assessed damages within thirty (30) calendar days, the amount of damages will be deducted against capitation payments due to the MCO or that become due at any time after assessment of the Liquidated Damages. The Department will make deductions until the full amount payable by the MCO is collected. All Liquidated Damages imposed pursuant to this Contract, whether paid or due, must be paid by the MCO out of administrative costs and profits.

Per 42 CFR §438.704(c), if the Department imposes Liquidated Damages on the MCO for charging premiums or charges in excess of the amounts permitted under the Contract, the Department will deduct the amount of the overcharge from the Liquidated Damage and return it to the affected enrollee.

If at any time BMS determines the MCO has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, BMS reserves the right to waive all or part of the Liquidated Damages.

Neither the occurrence of an event constituting an alleged MCO non-performance of this Contract nor the pending status of any claim for non-performance of Contract is grounds for the suspension of performance, in whole or in part, by the MCO of any duty or obligation with respect to the performance of this Contract.

The MCO is responsible for any damages imposed on the State or MCO arising from any non-compliance or non-performance related to the delivery of the covered services or deliverables under this Contract by the MCO, its Subcontractors or agents.

When it suspends payments under this section, the Department must submit to the MCO a list of the enrollees for whom payment is being suspended, the nature of service(s) denied, and payments the Department must make to provide covered Contract services. When all payments have been made by the Department for the MCO covered Contract services, the Department will reconcile the estimated suspension against actual enrollee payments.

The Department may suspend MCO payments in accordance with 42 CFR §455.23 in case of a credible allegation of fraud against the MCO.

6.8 Dispute Resolution

This Contract is not subject to arbitration. Any action concerning MCO non-performance under this Contract will be decided in accordance with Article II, Section 6 of this Contract by the Contracting Officer who will put his/her decision in writing and serve a copy on the MCO and Department as soon as administratively possible after the MCO non-performance was identified. The Contracting Officer's decision will be final unless within ten (10) business days of the receipt of such copy, the MCO or Department files with the Contracting Officer a written appeal.

As a response to an appeal, the Contracting Officer must issue his/her recommended course of action to the Commissioner for either the BMS or BSS. The Commissioner will review the Contracting Officer's recommendation and issue a decision on the appeal within ten (10) business days.

Should the MCO disagree with the decision, the MCO can request a hearing before an administrative law judge within ten (10) business days, who will take evidence and hear oral argument. In connection with any appeal proceeding under this subsection, the MCO will be afforded an opportunity to be heard and to offer evidence and oral argument in support of its appeal. At such hearing, the Department will also offer evidence and oral argument in support of its position.

The administrative law judge, who will serve as an impartial fact finder, will issue a proposed decision to the MCO and to the Department within sixty (60) calendar days of the end of the hearing. The MCO and/or the Department will have ten (10) business days after the mailing of the proposed decision to request a decision review. If such a request is made, the DoHS Secretary will, thereafter, issue a final decision. There must be no ex parte communications with the administrative law judge during pendency of the appeal. During any appeal process, the copies of all pleadings or other documents being filed in connection with the appeal must be delivered to the administrative law judge. The reasonable costs of an administrative appeal including costs of reporting and preparing a transcript will be paid by the party appealing. Such decision will be final except to the extent that the MCO appeals to the Circuit Court of West Virginia. The pendency of an appeal to the Secretary or the Circuit Court will not automatically stay any notice of termination which may be appealable.

Pending final determination of any dispute, the MCO must proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's direction.

The MCO's failure to follow the procedure set out above will be deemed a waiver of any claim which the MCO might have had.

The Department and the MCO agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this section unless the statute, rule, regulation, or guidelines can be read together with this section to give effect to both.

The State will provide the MCO with written notice of its intent to terminate, the reason for termination, and the time and place of any hearing. If after notice of termination of the Contract for default, it is determined by the State or a court that the MCO was not in default or that the MCO's failure to perform or make progress in performance was due to causes beyond control and without the error or negligence of the MCO, or any Subcontractor, the notice of termination will be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties will be governed accordingly.

In the event the State of West Virginia, Department of Administration Purchasing and/or the Department terminates the Contract in full or in part as provided in this clause, the State of West Virginia, Department of Administration Purchasing may procure services similar to those terminated, and the MCO will be liable for any excess costs for such similar services for any calendar month for which the MCO has been paid to provide services to Medicaid clients.

Prior to the termination for default of the MCO, the Department may take the following steps:

- After a hearing before the administrative law judge, if one is requested by the MCO as set forth in Article II, Section 6.8, provide the MCO with written notice of the decision affirming or reversing the proposed termination of the contract, and the effective date of the termination, if applicable; and
- For an affirming decision, give enrollees of the MCO notice of the termination, and information regarding enrollees' options for receiving covered services following the termination, and the right to terminate enrollment in the MCO immediately without cause.

In the event of a termination for default, the MCO must be paid for those services which the MCO has provided.

The MCO may terminate performance of work under this Contract in whole, or in part, with written notification to the State of West Virginia, Department of Administration Purchasing through the Department, whenever the Department fails to make payment for services under this Contract for sixty (60) calendar days and fails to cure such non-payment or make progress toward curing nonpayment within a period of thirty (30) calendar days after receipt of the MCO's written notice of termination.

The rights and remedies of the Department provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under this contract.

If the State of West Virginia, Department of Administration Purchasing through the Department terminates the Contract for default, the MCO will be responsible for all reasonable costs incurred by the Department, the State of West Virginia, or any of its administrative agencies to replace the MCO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to the MCO's failure to perform any service in accordance with the terms of the Contract.

6.10 Termination for Convenience

The State of West Virginia, Department of Administration Purchasing through the Department or the MCO may terminate this Contract at any time with at least a thirty (30) calendar day written notice. The effective date must be the first (1st) day of a month. The MCO must be paid the following:

6.14 Termination Obligations of Contracting Parties

Upon Contract termination, the MCO and Subcontractors must allow the Department, its agents, and representatives full access to the MCO's and Subcontractor facilities and records to arrange the orderly transfer of the contracted activities. These records include the information necessary for the reimbursement of any outstanding Medicaid or SNS claims.

Upon the date of notification of its intent to terminate the Contract, the MCO may no longer accept new enrollees. The MCO will remain responsible for providing services, including coverage of inpatient services, through the effective date of the Contract termination, to individuals enrolled with the MCO on or before the date of notification to the Department. The MCO must provide the Department with the names, primary care provider (PCP) assignments, and primary diagnosis of all enrollees with care needs that require Department pre-authorization, those currently receiving case management, and those with known future service needs (e.g., scheduled ambulatory surgery, pregnancy) by such date as determined by the Department, with weekly updates thereafter. The MCO must provide the Department with the names and treatment plans of enrollees with such plans.

Upon Contract termination, the MCO and Subcontractors must provide the Department with all required reports and data through the end of the Contract period as described in this Contract. This requirement includes encounter data, which must be submitted no later than ninety (90) calendar days after the end of the quarter in which the encounters occurred. The Department may request an interim encounter data submission ninety (90) calendar days after the termination of the contract.

Where this Contract is terminated due to default by the MCO:

- The Department will be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive services; and
- The MCO will be responsible for all reasonable expenses related to said notification.

Where this Contract is terminated for any reason other than default by the MCO:

- The Department will be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive services; and
- The Department will be responsible for all expenses relating to said notification.

6.15 MCO Operations Transition

MCO transition is defined as the activities that the MCO is required to perform upon termination or expiration of the Contract in situations where the MCO will transition data and documentation to the Department or a subsequent contractor. For purposes of this provision, "documentation" means all operational, technical, and user manuals used in conjunction with the software, services, and deliverables, in whole or in part, that the Department determines are necessary to view and extract application data in a proper format.

The MCO must provide the documentation in the formats in which the documentation exists at the expiration or termination of the Contract. The data, documentation, information, and services provided as detailed in this section must be provided at no additional cost to the Department or a subsequent contractor. The Department or subsequent contractor must receive and verify all relevant data, documentation, and information. If the Department determines that the data,

6.17 Waiver of Default or Breach

Waiver of any default will not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of the Contract will not be deemed to be a waiver of any other or subsequent breach and will not be construed to be a modification of the terms of the Contract unless stated to be such in writing, signed by an authorized representative of the Department and the MCO, and attached to the original contract.

6.18 Severability

If any provision of this Contract is declared or found to be illegal, unenforceable, or void, then both parties will be relieved of all obligations under that provision. The remainder of this Contract will be enforced to the fullest extent permitted by law.

6.19 Modification of the Contract in the Event of Remedies

The Department may propose a modification of this Contract in response to the imposition of a remedy under this Article. Any modifications must be reasonable, limited to the matters causing the exercise of a remedy and must be in writing.

7. POST-AWARD READINESS REVIEW

The MCO must satisfy all Readiness Review requirements as outlined in 42 CFR §438.66 and provided by the Department prior to the MCO or its Subcontractor(s) operational start date(s). The Department or its agents will conduct a Readiness Review to determine whether the MCO or its Subcontractor(s) have implemented all systems and processes necessary to begin serving enrollees.

A Readiness Review by the Department or its designated agent may occur if:

1. A new MCO is contracted by the Department;
2. A new Subcontractor is employed by the MCO;
3. An existing MCO's Subcontractor provides services in a new service area;
4. An existing MCO or its Subcontractor provides services for a new MCO program or population;
5. An existing MCO or its Subcontractor changes locations;
6. An existing MCO or its Subcontractor changes one (1) or more of its information management systems, claims processing or operational functions; or
7. A Readiness Review is requested by the Department, CMS, or ACF.

The Department, may, at its discretion, terminate the Contract, postpone the operational start date(s), or assess other contractual remedies if an MCO or its Subcontractors fail to timely correct all Readiness Review deficiencies within a reasonable cure period, as determined by the Department.

technology and infrastructure components and business area operations to provide immediate response and subsequent recover of West Virginia's data from any unplanned service interruptions. The BCP must include a business impact analysis, testing, awareness, training, and maintenance. The BCP must address a wide range of infrastructure and services recovery responsibility associated with, and/or arising from, partial loss of a function or of data for a brief amount of time to a worst-case scenario in which a man-made or natural disaster results in data center equipment or infrastructure failure or total system failure. The plan must address the following:

1. A description of the essential roles, responsibilities, and coordination efforts necessary to support recovery and business continuity.
2. Process for notifying BMS.
3. Identification of the MCO's disaster recovery location and equipment.
4. Implementation of appropriate security and privacy controls that are in place for the protection of sensitive and confidential state data on the disaster recovery platform, including encryption of transmitted and stored state data.
5. Procedures for data backup.
6. Description of testing plan and testing frequency. The MCO must periodically, and no less often than annually, conduct a BCP Review and exercise/drill at the MCO's own expense (e.g., simulated disasters and lower level failures) to demonstrate it can restore system functions per the requirements in this Contract. The review must test all components of the MCO's operation, including services provided by any third parties. The MCO must submit to BMS a written findings report within fifteen (15) Calendar Days of the date that the test is conducted. The MCO must develop a written CAP for any deficiencies noted in the test and must thoroughly re-test until satisfactory results are achieved and maintained. The MCO must submit the CAP to BMS within five (5) business days of the conclusion of test and re-testing must be continuous until system functions can be restored. The MCO must notify BMS in writing of its efforts and the outcomes of each test through successful resolution.
7. Written policies and procedures for emergency mode operations, including responding to an emergency or other occurrence (for example, fire, vandalism, System failure, and natural disaster) that damages Systems that contain electronic Protected Health Information.
8. Procedures for disaster recovery including restoration of data and recovery of business functions, business units, business processes, human resources, and the technology infrastructure.
9. Procedure to allow facility access in support of restoration of lost data and to support emergency mode operations in the event of an emergency. Access control will include procedures for emergency access to electronic information.

BMS, federal auditors, or the state auditor, reserve the right to conduct a site visit of the MCO's disaster recovery location with one (1) day prior notice.

The MCO must review and update its BCP annually for submission to BMS, and include a copy of the testing plan and results, by October 1 each year.

and its Subcontractors' materials and information pertinent to the services provided under this Contract, at any time, until the expiration of ten (10) years from the completion date of this Contract as extended or ten (10) years from the completion date of any audit, if longer. The MCO agrees to comply with the provisions of Section 1861 (v)(1)(I) of the Social Security Act, as amended, governing the maintenance of documentation to verify the cost of services rendered under this Contract. The MCO and its Subcontractors agree that authorized State representatives including, but not limited to, Department personnel, the State Auditor, and other State and/or any applicable Federal agencies providing funds will have access to and the right to examine the items listed above during the Contract period and during the ten (10) year post-Contract period, or ten (10) years after the date of the final resolution of all pending audit questions and litigation, if longer. During the Contract period, access to these items will be provided to the Department or its designee at all reasonable times. This may require the identification and collection of data for use by medical audit personnel. During the ten-year post-Contract or post-audit period, delivery of and access to the listed items will be at no cost to the State.

The State and its authorized agents may record any information and make copies of any materials maintained for the purposes of this Contract necessary for the audit, except enrollee and provider quality assurance and quality improvement records when confidentiality is protected by law.

Any Subcontract with an approved MCO Subcontractor must include a provision specifically authorizing audits in accordance with the terms set forth in this section.

8.4.1 Accounting

The MCO and its Subcontractors must maintain accounting records relating to the performance of the Contract. These accounting records must be maintained in accordance with generally accepted accounting principles.

8.4.2 Separate Accounting Records

The MCO and its Subcontractors must maintain separate books, records, documents, files and other evidence pertaining to the administrative costs and expenses of the Contract to the extent and in such detail as must properly reflect all revenues and all costs of whatever nature for which reimbursement is claimed under the provisions of the Contract. All such documents must be made available to the Department or its designee at its request and must be clearly identifiable as pertaining to the Contract.

8.4.3 Retention of Records

All financial and programmatic records, supporting documents, files, statistical records, and other records of enrollees, which are required to be maintained by the terms of this Contract and by 42 CFR §438.416, §438.5(c), §438.8(k), and §438.604, §438.606, and §438.610., must be retained for at least ten years from the date of expiration or until ten (10) years after the date on which any on-going 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 ten-year period, the records must be retained until ten (10) years after the completion of the action and resolution of all issues which arise from it, or until the end of the regular ten (10) year period, whichever is later. The MCO and its Subcontractors agree to retain the source records for its data reports for a minimum of ten (10) years and must have written policies and procedures for storing this information. The record retention policy is for all documentation, including but not limited to,

The Department reserves the right to disallow a proposed subcontracting arrangement if the proposed Subcontractor has been formally restricted from participating in a federal entitlement program (i.e., Medicare, Medicaid, and programs through ACF).

The MCO must submit a report listing each Subcontract, Subcontractor name, Subcontract effective dates and functions by July 1st of every year to the Department.

The requirements of this section do not apply to Subcontracts entered into for the provision of any of the following: utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.

The MCO's Subcontract agreement must require a written notice of intent to be furnished by the MCO or its Subcontractor in case of the Subcontract termination for any reason. A written notice of intent must be given within the following timeframes:

- Ninety (90) calendar days prior to the termination date of a Subcontract for systems operations or reporting;
- Thirty (30) calendar days prior to the termination date of a Subcontract for administrative services; and
- Thirty (30) calendar days prior to the termination date of any other Subcontract.

A written notice of intent is not required in case of a serious breach of a Subcontract. The MCO must provide the Department with a written notification no later than three (3) business days if a serious breach of a Subcontract occurs.

The MCO must provide the Department with a written notification no later than five (5) business days after receiving a written notice from a Subcontractor or giving a notice to Subcontractor of the intent to terminate a Subcontract for any reason.

Subcontracts must provide that all information that is obtained through performance under this Contract, including, but not limited to, information relating to applicants or enrollees of the Department programs, is confidential to the extent that confidential treatment is provided under state and federal law, rules, and regulations.

The MCO must maintain and keep current a Subcontractor monitoring plan for each of its Subcontractors, including methods for identification of risks and development of mitigation strategies for identified risks and any conflicts with a Subcontractor. In the event BMS has approved for key staff to be employed through a Subcontractor, the MCO must include information in its monitoring plan about such arrangement, role of the key staff member, meeting and reporting structure, and methods the MCO uses to assure requirements of the key staff position are met. The MCO must provide a copy of its Subcontractor monitoring plan within ten (10) business days of the Department written request.

The MCO is required to monitor the Subcontractor's performance on an ongoing basis consistent with 42 CFR §438.230. The MCO is solely responsible for the fulfillment of this Contract with the Department. The MCO is required to assume prime contractor responsibility for all services offered and products to be delivered whether or not the MCO is the provider of said services or product. The Department will consider the MCO to be the sole point of contact with regard to all contractual matters.

4. Is a partner in an MCO organized as a partnership.

8.7.1 Disclosure Report Requirements

This disclosure must include for each person:

- The name and address of the person, including the primary business address, every business location, and P.O. Box address, as applicable;
- Date of birth (DOB) and Social Security Number (SSN) (in the case of an individual);
- Tax identification number for a corporation with an ownership or control interest in the MCO or for a Subcontractor in which the MCO has a five percent (5%) or more interest;
- Whether the person (individual or corporation) with ownership or control interest in the disclosing entity and/or Subcontractor is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling;
- The name of any other organization in which a person with ownership or control interest in the MCO also has an ownership or control interest; and
- The name, address, DOB, and SSN of an agent or a managing employee of the disclosing entity.

8.7.2 Disclosure Reporting Schedule

The MCO must disclose information on individuals or corporations with an ownership or control interest in the MCO to the Department at the following times:

1. When the MCO submits a proposal in accordance with the state's procurement process;
2. When the MCO executes a contract with the Department;
3. When the state renews or extends the MCO contract;
4. Within thirty-five (35) calendar days after any change in ownership of the MCO; and
5. Within thirty-five (35) calendar days of the Department's request.

The MCO must also submit to the Department a copy of any information it submits to the Department of Insurance regarding disclosure of ownership or control interest.

8.7.3 Prohibited Affiliations with Individuals Debarred by Federal Agencies

In accordance with 42 CFR 438.610, the MCO cannot knowingly have a relationship with any of the following:

1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
2. An individual or entity who is an affiliate, as defined in the FAR at 48 CFR 2.101, of a person described above in item 1; and
3. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

8.7.4 Business Transactions of Medicaid Providers

Federal regulations contained in 42 CFR §455.105 require the MCO to disclose the following information related to business transactions within thirty-five (35) calendar days of request of the Secretary of DHHS: full and complete information about (1) the ownership of any Subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the previous twelve (12) month period and (2) any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any Subcontractor, during the previous five (5) years.

8.8 Disclosure of Legal Proceedings and Related Events

The MCO must notify the Department of all legal proceedings, actions, and events relating to the MCO or its Subcontractors, affiliates, including parent companies. At a minimum, the following matters must be disclosed:

1. Whistleblower or qui tam actions, complaints, or litigation;
2. Class-action complaints or lawsuits;
3. Legal actions or governmental investigations, alleging fraud or the possibility of fraud;
4. Bankruptcy proceedings or petitions where the MCO, or its Subcontractors, affiliates, including parent companies, are named as a debtor;
5. Any litigation, mediation, arbitration, between the MCO and its Subcontractor; and
6. Criminal actions brought against the MCO, or its Subcontractors, affiliates, including parent companies.

The MCO must provide written notification within thirty (30) calendar days after becoming aware of a matter. A summary, in the form of a memo, must meet the requirements of notification to the Department. All other legal proceedings, actions, and events may be requested at the Department's discretion, but are not required to be reported upon awareness of occurrence.

ARTICLE III: STATEMENT OF WORK

1. COVERED POPULATIONS

The following populations will be served by the MCO:

- Children and youth who are in foster care
- Individuals receiving adoption assistance
- Children ages three (3) up to twenty-one (21) eligible for the CSED waiver and enrolled in the MCO as slots are available
- Youth formerly in foster care up to age twenty-six (26) who aged out of foster care while enrolled in Medicaid in the state of West Virginia.

based on moral or religious objections at least thirty (30) days prior to the effective date of the policy for any particular service.

Changes to Medicaid or SNS covered services mandated by Federal or State law subsequent to the signing of this Contract will not affect the Contract services for the term of this contract, unless (1) agreed to by mutual consent, or (2) the change is necessary to continue to receive Federal funds or due to action of a court of law. For example, if Medicaid coverage were expanded to include new services, such services would be paid for via the traditional Medicaid FFS system unless covered by mutual consent between the Department and the MCO (in which case an appropriate adjustment to the payment rates would be made).

2.2 Additional Requirements/Provisions for Certain Services

2.2.1 Initial Health Assessment, Comprehensive Exam, and Follow-up Requirments for Children Entering or Re-entering Foster Care

All children entering or re-entering Foster Care must have:

- A comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exam within thirty (30) calendar days of placement in Foster Care; and
- A follow-up visit within ninety (90) calendar days of placement in Foster Care, as needed.

Once the child is enrolled in the MCO, the MCO will be responsible for working with the assigned CPS worker to ensure these important health assessments, exams, and follow-up visits are performed timely.

2.2.2 Initial Health Assessment for Other Enrollees Not in Foster Care

For all other MCO enrollees not newly entering or re-entering foster care, the MCO must ensure that an initial screening of each enrollee's health care needs is completed within thirty (30) calendar days of the effective date of enrollment.

2.2.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandated that all Medically Necessary services listed in Section 1905(a) of the Social Security Act be covered under Medicaid for the EPSDT benefit provided for Medicaid eligible children under the age of twenty-one (21). EPSDT services include all mandatory and optional Medically Necessary services (including treatment) and items listed in 42 USC 1396d(a) to correct or ameliorate defects, and physical and mental illness and conditions discovered by the HealthCheck screening. EPSDT services are included in the prepaid benefit package for children and adolescents up to age twenty-one (21). The federal government, through CMS, requires states to demonstrate an eighty percent (80%) compliance rate for EPSDT screening schedules.

In West Virginia, EPSDT is called HealthCheck. The MCO is responsible for working with parents, caregivers, and CPS workers to ensure all children and youth covered through this contract receive the EPSDT HealthCheck screenings according to the periodicity schedule or as determined to be medically necessary for the child.

2.2.3.1 EPSDT HealthCheck Requirements for the MCO

The MCO is required to:

The MCO, or designee if collaborating with the Bureau for Public Health, must provide all EPSDT eligible individuals or their representatives with accurate, current information about the EPSDT program using clear and non-technical language. The MCO must inform each new member under the age of twenty-one (21) about HealthCheck services as specified by 42 CFR §441.56 within five (5) calendar days of receipt of the monthly enrollment file. The MCO may meet this requirement by providing information with the new enrollee materials by that includes the following:

1. The benefits of preventive health care;
2. The services available under the EPSDT program and where and how to obtain those services;
3. A list of the intervals at which members under the age of twenty-one (21) should receive screening examinations, as indicated by the most recent version of the West Virginia Periodicity Schedule which aligns with the guidance published by Bright Futures/American Academy of Pediatrics (AAP);
4. A statement that the services provided under the EPSDT program are without cost to eligible individuals under twenty-one (21) years of age; and
5. A statement that necessary transportation and scheduling assistance is available to the EPSDT eligible individual upon request (Medicaid related non-emergency transportation is paid by the Department outside of the MCO capitation system).

2.2.3.3 Perform the EPSDT HealthCheck Screenings

MCOs must provide screenings (periodic comprehensive child health assessments) according to the West Virginia Periodicity Schedule to all enrollees eligible to receive them. The Periodicity Schedule is maintained by the Office of Maternal and Child Health within the West Virginia Bureau for Public Health and corresponds to the AAP's Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.

Covered screening services are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. At a minimum, the EPSDT HealthCheck screenings must include, but are not limited to:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development);
2. An unclothed physical exam that should be supervised;
3. Laboratory tests (including blood lead screening appropriate for age and risk factors);
4. Vision testing;
5. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices (ACIP);
6. Hearing testing;
7. Dental services (furnished by direct referral to a dentist for children beginning six (6) months after the first tooth erupts or by twelve (12) months of age)
8. Behavioral health screening; and

necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements.

2.2.3.5 Track EPSDT HealthCheck Referrals and Treatments

The MCO must establish a tracking system that provides up-to-date information on compliance with EPSDT service provision requirements including a Periodicity Schedule of preventive services and standards of care in the following areas:

1. Initial visit for newborns. The initial EPSDT screen must be the newborn physical exam in the hospital, birthing center, at home or other setting. Based in part upon the results of the birth score procedure conducted through the hospital or birthing center under the governance of the Bureau for Public Health, the periodicity of preventive pediatric visits must follow the schedule recommended by the AAP or the accelerated visit schedule set for infants identified as "at risk" through the birth score system.
2. Preventive pediatric visits according to West Virginia's Periodicity Schedule up to age twenty-one (21).
3. Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results. The MCO must employ processes to ensure timely initiation of treatment, if required, generally no more than six (6) months after the screening services.
4. Behavioral health, dental, and any other screenings performed for enrollees.
5. Missed periodic and preventive visits and notification to enrollees and/or their authorized representative of missed visits.

The MCO must have a reminder/notification system that is integrated with its tracking system to allow timely notifications of preventive visits coming due as well as to notify enrollees and/or their authorized representatives of any missed appointments, including referrals.

2.2.3.6 Report the EPSDT HealthCheck Results

The Department is responsible for ensuring that the MCO fulfills its contractual responsibilities to inform all families of the services available under EPSDT and how to access them.

The MCO must maintain data for medical, behavioral, and dental screenings and referral appointments in a standardized format to the extent feasible and appropriate. The MCO must review and ensure that data received from providers is accurate, timely, and complete. The MCO must facilitate routine tracking and trending of enrollee care issues to monitor, and assist in monitoring access, use and coordination of all services, including behavioral health services.

The MCO must submit to the Department a report due forty-five (45) calendar days after the end of each quarter which identifies its performance regarding EPSDT outreach/enabling services, screening and referral rates, well-care child visit rates, behavioral health visits, dental visits, and immunization rates. Reporting must include average turnaround times for processing of referrals and for enrollee appointments resulting from referrals broken out by service type (e.g., behavioral health, dental, physical therapy, etc.) (see Article III, Section 6.10, Reporting Requirements).

The MCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard (as defined above), turned out to be non-emergency in nature. Hospitals are required to evaluate each enrollee presenting for services in the emergency room and must be reimbursed for this evaluation. If emergency room care is later deemed non-emergency, the MCO is not permitted to bill the Medicaid patient; the MCO and the hospital must determine who pays for this care, except for the applicable non-emergency copays paid by the enrollee.

The MCO may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services which an enrollee seeks in an emergency. Placement in an IMD is considered an emergency service and as such, the MCO cannot require a prior authorization for placement in the IMD the first forty-eight (48) hours.

A medical screening examination needed to diagnose an enrollee's emergency medical condition must be provided in a hospital-based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 CFR §489.20, §489.24 and §438.114(b)&(c)). The MCO must pay for the enrollee's emergency medical screening examination, as required by 42 U.S.C. 1395dd. The MCO must reimburse providers for both the physician's services and the hospital's emergency services, including the emergency room and its ancillary services, so long as the "prudent layperson" standard (as defined above) has been met.

2.2.5 Post-Stabilization Care

The MCO must cover and pay for post-stabilization care services in the amount, duration, and scope necessary to comply with 42 CFR §438.114 and 42 CFR §422.113(c).

These regulations state that the MCO must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier whether or not that provider or supplier contracts with the MCO to provide services covered by the MCO. Post-stabilization care services are covered services the MCO is financially responsible for if they:

- Were pre-approved by the organization;
- Were not pre-approved by the organization because the organization did not respond to the provider of post-stabilization care services request for pre-approval within one (1) hour after being requested to approve such care or could not be contacted for pre-approval;
- Were obtained within or outside the organization that are not pre-approved by the MCO, provider or other MCO representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if:
    - The organization does not respond to a request for pre-approval within one (1) hour;
    - The organization cannot be contacted; or
    - The organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and the MCO physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue

MCOs must provide their Medicaid enrollees with sufficient information to allow them to make an informed choice including: the types of family planning services available, the availability of long-acting reversible contraceptives (LARC), their right to access these services in a timely and confidential manner, and their freedom to choose a qualified family planning provider both within and outside the MCO's network of providers. In addition, MCOs must ensure that network procedures for accessing family planning services are convenient and easily comprehensible to enrollees. MCOs must also educate enrollees regarding the positive impact of coordinated care on their health outcomes, so enrollees will prefer to access in-network services or, if they should decide to see out-of-network providers, they will agree to the exchange of medical information between providers for better coordination of care.

In addition, MCOs are required to provide timely reimbursement for out-of-network family planning and related sexually transmitted disease (STD) services consistent with services covered in their contracts. The reimbursement must be provided at least at the applicable West Virginia Medicaid FFS rate appropriate to the provider type (current family planning services fee schedule available from the Department).

The MCO, its staff, contracted providers and its contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation must keep family planning information and records confidential in favor of the individual patient, even if the patient is a minor. The MCO, its staff, contracted providers and its contractors that are providing cost, quality, or medical appropriateness reviews, or coordination of benefits or subrogation must also keep family planning information and records received from non-participating providers confidential in favor of the individual patient even if the patient is a minor. Maternity services, hysterectomies, and pregnancy terminations are not considered family planning services.

2.2.6.1 Conditions for Out-of-Network Reimbursement of Family Planning Services

All MCOs must reimburse out-of-network providers for family planning services rendered to enrollees. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. The following are the conditions under which family planning providers will be reimbursed for family planning services provided to Medicaid enrollees:

1. The family planning provider must be qualified to provide family planning services based on licensed scope of practice;
2. The family planning provider must submit claims on appropriate MCO-specific billing forms; and
3. The family planning provider must provide medical records sufficient to allow the MCO to meet its case management responsibilities. If an enrollee refuses the release of medical information, the out-of-network provider must submit documentation of such refusal.

In order to avoid duplication of services, promote continuity of care, and achieve the optimum clinical outcome for Medicaid enrollees, MCOs must encourage out-of-network family planning providers to coordinate services with MCO providers and to educate MCO enrollees to return to MCO providers for continuity of care. If a non-participating provider of family planning services detects a problem outside of the scope of services listed above, the provider must refer the enrollee back to the MCO.

public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation by individuals. The NEMT broker must approve ambulance, multi-passenger van services, and transportation by common carriers. The MCO must inform enrollees of how to access non-emergency Medicaid transportation as appropriate.

2.3.2 Outpatient Pharmacy

Simple or compound substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance (e.g., prescription drugs, family planning supplies, vitamins for children to age twenty-one (21), and prenatal vitamins) are covered by FFS Medicaid. Hemophilia-related clotting factor drugs, Spinraza, other drugs deemed by the Department as appropriate for FFS coverage, and Hepatitis-C virus (HCV)-related drugs will be covered by FFS Medicaid. Drugs and supplies dispensed by a physician, acquired by the physician at no cost, are not covered by Medicaid.

The Department will provide the MCO with pharmacy utilization data to support coordination of care for the enrollee.

The MCO remains responsible for all other provider-administered drugs, such as those provided as part of an inpatient stay, a bundled ER visit, or administered vaccinations. The MCO is permitted to negotiate and collect supplemental rebates with drug companies for provider-administered drugs. The MCO's provision for physician discretion and the medical needs of the patient must not be impaired by rebate agreements. The rebate amount shall be accounted for in the MLR calculation.

The MCO shall comply with Section 1004 of the SUPPORT for Patients and Communities Act and the Drug Utilization Review (DUR) regulations as described in section 1927(g) of the Act and 42 CFR part §456, subpart K. The MCO shall be subject to both prospective and retrospective requirements, as applicable, dependent on whether the medication is administered via point of sale or clinically.

The MCO must comply with all established criteria required by WV Medicaid before approving the initial coverage of any physician-administered agent which is currently available in a point-of-sale form. If exceptions to the criteria are considered appropriate or necessary, the MCO must obtain written consent for such variance from BMS Office of Pharmacy Services.

The MCO shall be subject to following provisions of Section 1004 of the SUPPORT for Patient and Communities Act:

1. Claim Reviews:
    a. Retrospective reviews on opioid prescriptions exceeding state defined limitations on an ongoing basis.
    b. Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.
2. Programs to monitor antipsychotic medications to children: Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines.

or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The MCO must not provide coverage under any circumstances for drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI).

The MCO cannot enhance the benefits provided to Medicaid enrollees, with the exception of clinical preventive services, without the prior approval of the Department.

In accordance with Article III, Section 4.8.5 State Fair Hearing Process, appeals that the MCO review for non-covered services are not eligible for submission through the state fair hearing process.

2.5 Other Requirements Pertaining to Covered Services

The MCO must assume responsibility for all covered medical conditions, inclusive of pre-existing conditions of each enrollee as of the effective date of enrollment in the plan. The MCO may not prohibit or otherwise restrict a covered health professional from advising his/her patient about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for that care or treatment are provided under the Contract, if the professional is acting within the lawful scope of practice.[5]

The MCO and its participating providers may not bill or collect any payment from enrollees for a Medicaid service that was determined not to be Medically Necessary or an SNS that was determined not to be Socially Necessary. Anyone who knowingly and willfully charges for any service provided to a patient under a State Plan approved under Title XIX or under a MCO Contract under 1903(m) of the Social Security Act, money or other consideration at a rate in excess of the rates established by the Department or Contract will be guilty of a felony and upon conviction will be fined no more than $25,000 or imprisoned for no more than five (5) years, or both.

2.6 Requirements Pertaining to Medicaid Managed Care Programs

The MCO must follow the benefit packages and policies of Medicaid managed care programs as required by this Contract and Contract Appendices. The MCO should refer to the FFS Medicaid provider manuals available on the Department website for an explanation of service limitations.

2.6.1 PCP Responsibilities

PCPs will be the MCO enrollee's initial and most important contact with the Medicaid MCO. The PCPs' responsibilities are outlined in Article III, Section 3.2 of the Contract.

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[5] The term "health care professional" means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the Managed Care Plan's Contract for the services. A health care professional includes the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse, registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

The MCO must contract with the full array of providers necessary to deliver a level of care that is at least equal to the community norms and meet the travel time, appointment scheduling, and waiting time standards included in this contract.

The MCO must maintain and monitor a network of appropriate, credentialed providers, supported by written arrangements, that is sufficient to provide adequate access (as defined by the Department) to covered services (including the appropriate range of preventive, primary care, and specialty services) and to meet the needs of the population served. In establishing and maintaining the network, the MCO must consider the following:

- Anticipated enrollment under this Contract;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the specific populations covered by the MCO;
- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish all contracted services;
- Numbers of network providers who are not accepting new patients; and
- Geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by these enrollees, and whether the location provides physical access for enrollees with disabilities;
- Recruitment strategies for new or modified provider types, including, but not limited to, publicly supported providers; and
- Recruitment strategies for increasing PRTF capacity statewide to address severe mental health challenges such as sexual abuse, fire starting, combativeness, and severe conduct disorder behaviors.

The MCO may not require providers who agree to participate in the MHP Program to contract with the MCO's other lines of business.

If the MCO fails to build and/or maintain a provider network that meets the managed care network adequacy standards established by the Department, or is unable to ensure enrollees' access to the full array of covered services, BMS may impose or pursue one (1) or more remedies in accordance with Article II, Section 6.4.

3.1.2 Availability and Access Standards

The MCO must ensure that all covered services, including additional or supplemental services contracted by or on behalf of Medicaid enrollees, are available and accessible as required in 42 CFR §438.68, §438.206, and §438.207. The MCO must have policies and procedures, including coverage rules, practice guidelines, payment policies and utilization management, that allow for individual medical necessity determinations. Policies and procedures must outline how cases of medical necessity will be handled when medical service limits or prescription limits are met, per the Department's policies.

The Department has set minimum provider network adequacy standards that the MCO must meet or exceed as specified in Appendix K. They include standards for:

- PCPs;

3.1.2.2 Provider Hours Operation

In accordance with 42 CFR §438.206(c)(1)(ii), the MCO must ensure that the hours of operation of its providers are convenient, do not discriminate against enrollees, and are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS. The MCO must ensure that waiting times at sites of care are kept to a minimum and ensure that the waiting time standard for Medicaid enrollees is the same standard used for commercial enrollees. Providers cannot discriminate against Medicaid enrollees in the order that patients are seen or in the order that appointments are given (providers are not permitted to schedule Medicaid-only days).

In accordance with 42 CFR §438.206(c)(iii), when Medically Necessary, the MCO must make services available twenty-four (24) hours a day, seven (7) days a week. In accordance with 42 CFR §438.206(c)(iv), the MCO must establish a mechanism to ensure that providers comply with the access standards set forth in this contract. The MCO must regularly measure the extent to which providers in the network comply with these requirements and take remedial action if necessary.

3.1.2.3 Provider Cultural Competency Requirements

In accordance with 42 CFR §438.206(c), the MCO must ensure that services are provided in a culturally competent manner to all enrollees, 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. The MCO must also ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

3.1.2.4 Timeliness of Access to Care

In accordance with 42 CFR §438.206(c)(1)(i), the MCO must have standards for timeliness of access to care and enrollee services that take into account the urgency of the need for services and that meet or exceed such standards as may be established by the Department. In accordance with 42 CFR §438.206(c), the MCO must also regularly monitor its provider network's compliance with these standards, and take corrective action as necessary. The MCO must have protocols for identifying enrollees experiencing barriers with access to care and who cannot be reached by the MCO, including use of data to support improved access and overall outcomes. Methods may include, but not be limited to, review of focus group and survey findings, analysis of utilization, complaints and grievances, PCP change requests, out-of-network referrals and ER usage.

Current Department standards for timeliness state that:

- Emergency cases must be seen immediately or referred to an emergency facility;
- Urgent cases must be seen within forty-eight (48) hours;
- Routine cases other than clinical preventive services, must be seen within twenty-one (21) calendar days (exceptions are permitted at specific times when PCP capacity is temporarily limited);

MCO is allowed thirty (30) additional calendar days to investigate the quality or safety concern(s), after which, notice of the application determination must be made to the individual provider, clinic, or facility.

For each institutional provider or supplier, the MCO must determine, and redetermine at specified intervals, that the provider or supplier is licensed to operate in the state, is in compliance with any other applicable state or federal requirements, and is reviewed and approved by an appropriate accrediting body or is determined by the MCO to meet standards established by the MCO itself.

The MCO must submit a report to the Department monthly with the names, National Provider Identifiers (NPIs), and Employer Identification Number (EIN) or Medicaid ID of any health care professional, institutional provider, or supplier that has been the subject of program integrity actions. Actions may include denied credentialing, suspension, termination, CAPs, fines, or sanctions because of concerns about provider fraud, integrity, or quality deficiencies during the prior calendar month. The report must also state the action taken by the MCO (e.g., denied credentialing, education). This information must be reported using the appropriate template created by the Department. Suspensions, terminations, providers denied credentialing, and providers not renewed are reported on the Suspension and Adverse Enrollment Action Report template. Other program integrity actions are reported on the Fraud, Waste, and Abuse (FWA) Monthly Report template. Additional information can be found in Article III, Section 9.1 of this Contract. The MCO must also report any health care-related criminal convictions, when disclosed, to the Department. The MCO must also notify appropriate licensing and/or disciplinary bodies and other appropriate authorities.

The MCO must ensure compliance with Federal requirements prohibiting employment or contracts with individuals excluded from participation under Medicaid, Medicare, or the Children's Health Insurance Program, as required by 42 CFR §438.610. The MCO must provide written disclosure of any prohibited affiliation, as directed in 42 CFR §438.608 (c)(1). The MCO must not contract with providers that have been terminated from Medicare, Medicaid, or CHIP pursuant to 42 CFR §455.101.

The MCO may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This law may not be construed to prohibit the MCO from including providers only to the extent necessary to meet the needs of the MCO's enrollees from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the MCO. If the MCO declines to include providers in its network, the MCO must give the affected providers written notice of the reason for its decision.

The formal selection and retention criteria used by the MCO may not discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions.

3.1.4.1 Enrollment with the State

All network providers that order, refer, or render Medicaid covered services must enroll with the Department, through the fiscal agent, as a Medicaid provider, as required by 42 CFR

- Professional liability claims history;
- Good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility (this requirement may be waived for practices which do not have or do not need access to hospitals);
- The provider holds current, adequate malpractice insurance with minimum coverage requirements of $1 million per individual episode and $1 million in the aggregate;
- Any revocation or suspension of a state license or DEA/ Bureau of Narcotics and Dangerous Drugs (BNDD) number;
- Any curtailment or suspension of medical staff privileges (other than for incomplete records);
- Any censure by the State or County Medical Association; and
- Any enrollee complaints.

In addition, the MCO must request information on the provider from the National Practitioner Data Bank and appropriate state licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board and/or Dental Board.

During the recredentialing process, the MCO must re-verify and update all of the above information, and consider performance indicators such as those collected through the quality assurance and performance improvement program (see Article III, Section 7 of this contract), the utilization management system, the grievance system, enrollee satisfaction surveys, enrollee complaints, and other activities of the MCO.

All contracted providers must meet the credentialing and recredentialing requirements listed in this Contract.

All providers must notify the MCO no less than thirty (30) calendar days in advance when they relocate or open a new office; the MCO shall update the provider's records within thirty (30) calendar days of receipt of notification from BMS of the changes.

3.1.6 Additional Credentialing and Recredentialing Criteria for Certain Providers

3.1.6.1 Credentialing and Recredentialing Criteria for PCPs, OBGYNs, and Other Specialists

Additional credentialing criteria for PCPs, OBGYNs, behavioral health providers and other high-volume specialists must include a visit to the provider's office, documenting a structured review of the site and medical record keeping practices to ensure conformance with the MCO standards. The MCO must maintain a recredentialing policy with all activities continuing to be conducted every three (3) years. Site visits are not required at the time of recredentialing.

Each specialty provider shall ensure his or her respective service delivery site meets all applicable requirements of the law and has the necessary and current license, certification, accreditation, or designation approval per state requirements.

information needed for children in foster care, appropriate utilization of psychotropic medications;

- Assisting enrollees in foster care and enrollees with complex needs, including, but not limited to, opportunities for standing referrals, opportunities for specialists to serve as PCPs, and availability of disease management;
- Training in a Trauma-Informed Approach to care including screening /identifying, understanding, and responding to the effects of all types of trauma, including working with youth who may have been exposed to adverse childhood experiences (ACEs);
- Training on mandated reporters to support applicable State Code, including, but not limited to, WV Code §49-2-803, as defined by the Agency;
- Information on the effect of abuse and neglect on the developing brain;
- Information on the effect of intrauterine assault, fetal alcohol syndrome and shaken baby syndrome;
- Training on the Contractor's authorization and referral processes;
- Any condition-specific utilization management protocols or standards;
- Behavioral health evidence-based practices, including screening and identification;
- CANS assessment, as applicable to the provider,
- How to access services offered by other agencies, such as wraparound and Children's Mobile Crisis and Response (CMCR) services (via the Department training vendor);
- Roles and responsibilities of MCO and wraparound care management/coordination; and
- For PCPs, training in dental screenings to ensure appropriate referrals, including EPSDT process, to make referrals to the Assessment Pathway for additional evaluation and referral to community-based services, availability of the children's crisis and referral line and mobile response, and all home and community based services available for children with mental health needs.

3.1.8 Network Changes

In addition to reporting quarterly on the size and composition of its provider networks, the MCO must notify the Department of any changes to the composition of its provider network that materially affect the MCO's ability to deliver all capitated services within seven (7) calendar days of such change identified. The MCO must provide the Department with advanced written notice of any PCP network deletions within seven (7) calendar days. The MCO must report any disenrollment or termination of hospitals from the MCO's network to the Department within one (1) business day of disenrollment or termination.

The MCO must make a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the enrollee must be provided by the later of thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after the issuance of the termination notice. In the case of the termination of a PCP, the MCO

PCPs for certain individuals will not count toward the standard, unless these providers are willing to serve as the PCP for other enrollees. The provider-to-enrollee ratio is distinct from the requirement in the MCO contract regarding the total assigned panel size for any individual PCP.

3.2.2.1 PCP Enrollee Panels

The MCO is expected to ensure that the Medicaid enrollee panel of any PCP in its network does not exceed two thousand (2,000) Medicaid enrollees. The two thousand (2,000) Medicaid enrollee limit applies to each PCP. In the case of PCP teams (see below), this ratio may be adjusted. Exceptions to this limit may be made with the consent of the physician and the Department. Reasons for exceeding the limit may include: 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.

Recognizing that precise numerical ratios are not readily enforceable, the MCO must take measures to ensure compliance with this requirement such as monitoring PCPs' panels and enrollees' access to PCPs. the Department will monitor PCP panels across MCOs and notify each affected MCO if the total Medicaid enrollee panel of a PCP in its network exceeds two thousand (2,000) Medicaid enrollees. MCOs must reduce the caseload for PCPs with panels above two thousand (2,000) Medicaid enrollees across the program unless one (1) of the exceptions above is granted.

3.2.3 Assignment of PCP

The MCO must have written policies and procedures for assigning each of its enrollees to a PCP. The MCO will assume responsibility for assisting the enrollee with PCP selection. The MCO must make a PCP assignment within five (5) calendar days after a Medicaid beneficiary is enrolled in the MCO. The process whereby the MCO assigns PCPs to enrollees must take into consideration such known factors as current provider relationships, age, the child's placement (physical location), claims history, and input by the Department caseworker. The MCO then must notify the enrollee or the enrollee's representative in writing of his or her PCP's name, location and office telephone number, and the process for selecting a new PCP if the enrollee so desires. The MCO must confirm enrollees are aware of their PCP assignment and provide the opportunity to change their PCP assignment during the enrollee "welcome call" as defined in Article III, Section 4.5.1.

Enrollees with a disabling condition, chronic illness or who are SSI eligibles, must have a choice of specialist physician to serve as their PCP. The specialist physician must agree to perform all PCP duties required in the Contract and the PCP duties must be within the scope of the specialist's license. The MCO should provide enrollees with a description of any MCO approvals required for selection of a specialist as a PCP and process for requesting approval.

3.2.4 Types of Primary Care Providers (PCPs)

The MCO is required to contract with a mix of PCPs to ensure the primary care needs of all enrollees are met. The MCO may designate the following providers as PCPs, as appropriate:

3. The enrollee's PCP ceases to participate in the MCO's network;
4. The enrollee's behavior toward the PCP is disruptive, and the PCP has made all reasonable efforts (three (3) attempts within ninety (90) calendar days) to accommodate the enrollee; or
5. The enrollee has taken legal actions against the PCP.

3.2.7 PCP Panel Monitoring

The MCO must maintain written policies and procedures for monitoring participating PCP panel status and capacity. At a minimum, MCO policies and procedures must capture PCP panel capacity monitoring, PCP notifications of its panel size, changes in the PCP panel status, and limits.

The MCO must furnish each PCP with a current list of enrollees assigned to that provider no later than five (5) business days after the end of each month, unless the PCP agreed to an alternative schedule. The MCO may offer and provide such information in alternative formats, such as through access to a secure internet site, when such format is acceptable to the PCP.

The MCO must have a process in place to allow for enrollee reassignment upon PCP request if the enrollee falls outside the provider's provider type.

3.3 Specialty Care Providers, Hospitals and Other Providers

The MCO must contract with a sufficient number and mix of specialists and hospitals so that the enrolled population's anticipated specialty and inpatient care needs can be substantially met within the MCO's network of providers. The MCO must also have a system to refer enrollees to out-of-network providers if appropriate participating providers are not available, which includes, but is not limited to the following:

1. Enrollee and/or providers requesting out-of-network referrals;
2. An enrollee continuing an existing relationship with an out-of-network provider or a provider leaving the MCO's network; and
3. Durations permitted for enrollees to see out-of-network providers that refuse to contract with the MCO for ongoing courses of treatment past the first ninety (90) calendar days of enrollment.

The MCO must make referrals available to enrollees when it is medically appropriate. The MCO must have policies and written procedures for the coordination of care and the arrangement, tracking, and documentation of all referrals.

Enrollees must have access to certified pediatric or family NPs and certified nurse midwives, even if such providers are not designated as PCPs.[9] The MCO must contract with these providers to the extent practical.

The MCO must maintain a sufficient network of laboratories, which may include independent laboratories, clinical diagnostic laboratories, hospital outpatient departments, provider offices,

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[9] Since federal law requires states to assure access to certified pediatric or family nurse practitioners and certified nurse midwives, and states are not allowed to waive this requirement, the MCOs must provide access to these services.

enrollees. For those services defined as public health services under State law, the MCO may choose either to provide these services itself or to Contract with local health departments. However, if an MCO enrollee seeks such a service directly from a non-contracted local health department, the MCO must pay for the service at the lesser of the health department's fee rate or the Medicaid fee rate.

The MCO must provide the following core services to Medicaid managed care enrollees and must reimburse the local health departments as specified:

1. All STD services including screening, diagnosis, and treatment;
2. Human immunodeficiency virus (HIV) services including screening and diagnostic studies;
3. Tuberculosis services including screening, diagnosis, and treatment; and
4. Childhood immunizations. The MCO must obtain vaccines from the State Bureau for Public Health's Immunization Program. Any time an MCO enrollee seeks immunizations from a governmental public health entity, the MCO must pay for such services at current Medicaid FFS rates for administration costs only. For Medically Necessary situations, non-Vaccines For Children (VFC) vaccines administered by governmental public health entities to MCO clients, the MCO must reimburse for the cost of the vaccines. The MCO must encourage providers to refer their patients to these programs.

Environmental lead assessments for MCO children with elevated blood levels will be reimbursed directly by the State Bureau for Public Health. The MCO is responsible for the blood lead screenings.

The MCO must work with the local health departments to coordinate the provision of the above services and to avoid duplication of services.

Local health departments providing Medicaid services must have the right to participate in the MCO network, so long as such providers comply with the terms and conditions of the MCO provider Contract and provider qualification and credentialing process.

3.4.3 Critical Access Hospitals (CAH)

The MCO is encouraged, but not required, to contract with Critical Access Hospitals (CAH) for inpatient and outpatient hospital services.

3.4.4 Primary Care Centers

The MCO is encouraged, but not required, to contract with state-designated primary care centers to provide services.

3.4.5 School-Based Health Centers

School-based health centers (SBHCs) provide general, primary health care services to school-aged children. The State recognizes these centers as increasingly important providers of primary health care, especially in rural communities which face shortages of PCPs. The Department encourages the MCO to Contract with or develop cooperative agreements with SBHCs. Such agreements would recognize the MCO as the medical home for the child, define the process for referring students to MCO network providers, spell out procedures for sharing medical

3.4.9 Indian Health Providers

The MCO must follow the requirements related to Indians, Indian Health Care Providers, and Indian Managed Care Entities in accordance with the terms of 42 CFR §438.14.

3.5 Mainstreaming

The State considers mainstreaming of Medicaid beneficiaries into the broader health delivery system to be important. The MCO must accept responsibility for ensuring that network providers do not intentionally segregate Medicaid enrollees in any way from other persons receiving services. Examples of prohibited practices include, but are not limited to, the following:

1. Denying or not providing to an enrollee any covered service or availability of a facility;
2. Providing to an enrollee any covered service which is different, or is provided in a different manner or at a different time from that provided to other enrollees, other public or private patients or the public at large;
3. Subjecting an enrollee to segregation or separate treatment in any manner related to the receipt of any covered service; and
4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, program membership or physical or mental disability of the participants to be served.

PCPs are not permitted to close their panels to MHP enrollees if they have not closed their panels to other patients (e.g., uninsured, patients with commercial insurance, etc.). Should a PCP close its panel and later decide to begin accepting new patients, the PCP must admit patients on a first come first serve basis including MHP enrollees. However, if a PCP has the maximum of two thousand (2,000) Medicaid enrollees, the PCP may admit additional, non-Medicaid patients.

3.6 Provider Services

3.6.1 Provider Services Department

The MCO must maintain a Provider Services Department and operate a toll-free provider phone line for at least eight (8) hours a day during regular business hours.

3.6.1.1 Responsibilities of the MCO Provider Services Department

The Provider Services Department is responsible for the following, but not limited to:

1. Assisting providers with questions concerning enrollee eligibility status;
2. Assisting providers with plan prior authorization and referral procedures;
3. Assisting providers with claims payment procedures;
4. Handling provider complaints;
5. Providing and encouraging training to providers to promote sensitivity to the special needs of this population;
6. Educating providers about the MHP program; and

The Department will provide two (2) model provider contracts. One will be tailored to use with Medicaid service providers and the other will be tailored to use with SNS providers. The MCO must resubmit the revised model provider contracts to the Department any time it makes substantive modifications to such agreements.

3.6.3.1 Medicaid Provider Contract

At a minimum the MCO's Medicaid provider contracts and addenda must include the following provisions:

1. Enrollees will be held harmless for the costs of all Medicaid-covered services provided except for applicable cost-sharing obligations. The Contract must state that the providers must inform enrollees of the costs for non-covered services prior to rendering such services. The provider contract must state that the MCO's enrollees may not be held liable for the MCO's debts in the event of the MCO's insolvency; providers may not balance-bill;
2. Physicians will maintain adequate malpractice insurance with minimum coverage requirements of $1 million per individual episode and $1 million in the aggregate;
3. Reimbursement terms: The Contract must provide a complete description of the payment method or payment amounts applicable to a provider. The MCO provider Contract or provider manual must explain to providers how to submit a clean claim including a complete listing of all required information, including claims coding and processing guidelines for the applicable provider type. The MCO must pay both in-network and out-of-network providers within thirty (30) calendar days of clean claims receipt. The MCO provider must understand and agree that the Department is not liable or responsible for payment for covered services rendered pursuant to the MCO provider contract;
4. Requirement that providers attest to the following certification for claims for Medicaid goods and services. The certification must include the following information: All statements are true, accurate, and complete; no material fact has been omitted; all services will be medically necessary to the health of the specific patient; and understanding that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law;
5. Clear definition of each party's termination options;
6. Requirements for provider disclosure of ownership and control, in accordance with 42 CFR §455.104. The MCO provider contracts must include language defining ownership per 42 CFR §455.101. The MCO provider contracts or disclosure forms must request the provider to disclose information on ownership and control, and information on interlocking relationships per 42 CFR §455.104 (b)(3). A provider that is a business entity, corporation, or a partnership must disclose the name, DOB, SSN, and address of each person who is provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider or in the provider's Subcontractor. The address for corporate entities must include as applicable: primary business address, every business location, P.O. Box address, and tax ID. Contracts or disclosure forms must solicit information on interrelationships of persons disclosed per 42 CFR §455.104 (b). MCO contracts or

providers' performance of its obligations under the MCO provider contracts; and 2. any information in its possession sufficient to permit the Department to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. MCO provider contracts must include a provision explaining that, if the network provider places required records in another legal entity's records, such as a hospital, the network provider is responsible for obtaining a copy of these records for use by the above named entities or their representative;

12. Requirement for providers to comply with 42 CFR §438.104. The Contract must prohibit providers from engaging in direct marketing to enrollees that is designed to increase enrollment in a particular MCO. The prohibition must not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance;

13. Requirement to comply with Section 6032 of the Deficit Reduction Act of 2005, if the network provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources). A provider must:

    a. Establish written policies for all employees, managers, officers, contractors, Subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
    b. Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing FWA.
    c. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing FWA;

14. Requirement to comply with the HIPAA (Public Law 104-191), and the Health Information Technology for Economic and Clinical Health (HITECH) at 42 U.S.C. 17931 et. seq. The Contract must explain that the provider must treat all information that is obtained through the performance of the services included in the provider Contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or enrollees of the Department programs.

15. Requirement that provider may not interfere with or place any liens upon the State's right or the MCO's right, acting as the State's agent, to recovery from third party resources;

16. Requirement for provider to comply with 42 CFR §422.128 and West Virginia Health Care Decisions Act relating to advance directives;

17. Description of the MCO's provider complaint and appeal processes. The processes must comply with the requirements of this Contract, 42 CFR §438.414, and must be the same for all providers;

18. The provider contract must prohibit providers from collecting copays for missed appointments;

3.7 Provider Reimbursement

3.7.1 General

The Department believes that one of the advantages of a managed care system is that it permits MCOs and providers to enter into creative payment arrangements intended to encourage and reward effective utilization management and quality of care. The Department therefore intends to give MCOs and providers as much freedom as possible to negotiate mutually acceptable payment terms. However, reimbursement rate amounts over one hundred and two and five tenths percent (102.5%) of the Medicaid FFS rates are not included in data as part of rate setting to develop the PMPM capitation payment for the MCO.

Regardless of the specific arrangements the MCO makes with providers, the MCO must make timely payments to both its contracted and non-contracted providers, subject to the conditions described below. This includes making a full payment rather than installment payments for a course of treatment if FFS reimburses the entire cost of the treatment at the initiation of service. Additionally, the MCO must accept electronic claims as well as paper claims from providers. The MCO must accept Medicaid claims submitted using the enrollee's Medical Assistance ID (MAID). The MCO must also require all Medicaid claims for payment for items or services that were ordered to contain the NPI of the physician or other professional who ordered or referred such items or services.

The MCO's claims processing systems and guidelines shall meet minimum standards set by CMS including but not limited to upholding payment policies that comport with the National Correct Coding Initiatives (NCCI) edits and/or other claims payments guidance defined by CMS.

The MCO must educate providers about the claims submission process and how to request reconsideration of and appeal for denied claims. The MCO must include instructions in its provider manual for the reconsideration and appeal process, including timeframes for filing the request and the allowable levels of appeal in accordance with Department policy.

The MCO may not seek recoupment of any provider payments beyond twenty-four (24) months from the date of service unless such recoupment is due to provider FWA.

3.7.2 In-Network Services

Subject to Article III, Section 3.7.7, Timely Payment Requirement, the MCO must make timely payment within thirty (30) calendar days for clean claims to in-network providers for Medically Necessary, covered Contract services when:

1. Services were rendered to treat a medical emergency;
2. Services were rendered under the terms of the MCO's Contract with the provider;
3. Services were prior authorized; or
4. Retro-authorization meeting medical necessity has been granted due to the nature of service.

3.7.3 Out-of-Network Services

Subject to Article III, Section 3.7.7, Timely Payment Requirement, the MCO must make timely payments within thirty (30) calendar days for clean claims to out-of-network providers for Medically Necessary, covered services when:

3. **Subsequent Screening and Treatment:** An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition.
4. **Notification of Enrollee's PCP:** The MCO may not refuse to cover emergency services solely based on the emergency room provider or hospital not notifying the enrollee's PCP, MCO, or the Department of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services. Nothing in this provision precludes the MCO from complying with all other emergency service claims payment requirements as set forth in this contract.
5. **Absence of a Clinical Emergency:** If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, then the determining factor for payment liability should be whether the enrollee had acute symptoms of sufficient severity at the time of presentation. In these cases, the MCO must review the presenting symptoms of an enrollee and must pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard. If a Medicaid beneficiary believes that a claim for emergency services has been inappropriately denied by a MCO, the beneficiary may seek recourse through the MCO or BMS appeal process.
6. **Referrals:** When an enrollee's PCP or other MCO representative instructs the beneficiary to seek emergency care in-network or out-of-network, the MCO is responsible for payment for the medical screening examination and for other Medically Necessary emergency services, without regard to whether the patient meets the prudent layperson standard described above.

The MCO must promptly pay for all covered emergency services, including Medically Necessary testing to determine if a medical emergency exists, that are furnished by providers that do not have arrangements with the MCO. This includes emergency services provided by a non-participating provider when the time required to reach the MCO's facilities, or the facilities of a provider with which the MCO has contracted would have meant risk of permanent damage to the enrollee's health.

3.7.6 CAH Reimbursement

When contracting with CAH, the MCO must make payment to CAH at the prevailing Medicaid reimbursement rate. The MCO's contracts with CAH must stipulate this reimbursement arrangement. Upon Department notification to the MCO of any changes to the CAH reimbursement rates, the MCO must update payment rates to CAH effective from the designated Department effective date. The MCO must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The new payment rate must be loaded into the MCO's claims payment system within thirty (30) calendar days of notification by the Department of the payment rate change.

3.7.7 Timely Payment Requirement

The MCO must agree to make timely claims payments to both its contracted and non-contracted providers for all claims that occur during the contract period. A claim is defined as a bill for services, a line item of service, or all services for one enrollee within a bill. A clean claim is

5. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

3.7.9 Medicaid Provider Rate Changes

In the case of provider reimbursement that is tied to the Medicaid FFS rate schedule, the MCO is required to implement any rate changes adopted by the Department within thirty (30) calendar days of notification of the rate change. The MCO must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The MCO must reprocess any claims paid between the notification date and the system load date to the updated rate. This provision does not apply to payments made to CAH under Article III, Section 3.7.6 or payments made to FQHCs/RHCs per Article III, Section 3.4.1.

3.7.10 Alternative Payment Models (APM)

The Department supports a value-based health care system where enrollee experience and population health are improved, the trajectory of health care cost is contained through aligned incentives with MCO and provider partners, and there is a commitment to continuous quality improvement and learning. To support this effort, the MCO is required to administer APMs that shift from FFS reimbursement to reimbursement that rewards improved delivery of health care. APMs shall address quality of care including, but not limited to, social determinants of health (SDoH), use of evidence-based practices, post-discharge planning, and services. Post-discharge planning and services include, but are not limited to, additional SUD treatment, housing support, employment support, and transportation.

The MCO must implement and administer APM arrangements that account for at least twelve percent (12%) of enrollees enrolled during the State Fiscal Year, excluding maternity kick provider payments. BMS may increase this percentage in each subsequent contract year based on ongoing review of reporting and performance.

3.7.10.1 Design of APM Models

The MCO must design and implement payment models with network providers that tie reimbursement to measureable outcomes. APMs may include, but are not limited to the following:

1. Primary care incentives;
2. Payment for performance;
3. Shared savings arrangements;
4. Risk sharing arrangements;
5. Episodes of care/bundled payments; and
6. Capitation Payments with Performance and Quality Requirements.

Prior authorization and utilization management activities do not qualify as APMs.

3.7.10.2 APM Activities Report

The MCO is required to submit a report to the Department annually on its APM activities. The report specifications are outlined in Appendix H but must include:

- If the MCO is required to conduct enrollee/disenrollee surveys, provide a summary of the survey results to the Department and, upon request, to enrollees.
- Information on the physician incentive plan to enrollees, upon request.

The MCO must comply with any additional rules regarding physician incentives released by CMS.

4. ENROLLMENT & ENROLLEE SERVICES

The State will enroll eligible individuals into the MHP program and provide the MCO with an enrollment roster that identifies enrollees, including all new enrollees, on a daily and monthly basis. The MCO shall have in place policies and procedures regarding acceptance of enrollment files, which include, but are not limited to, the following: processing of 834 enrollment files, processes for reconciliation of enrollees against the monthly 820 capitation file, identification of any errors in the files, and communication to BMS to resolve identified issues.

All enrollment activities are subject to the standards and requirements set forth in this contract.

In accordance with West Virginia Code § 9-5-12, the MCO shall provide services to pregnant women and newborns up to one (1) year postpartum.

4.1 Marketing

4.1.1 Marketing Plan

The MCO must submit a marketing plan to the Department for prior written approval annually by October 1st of each Contract year. The Department will review and approve the marketing plan and all attached marketing materials within forty-five (45) calendar days.

If the marketing plan is modified during the Contract year, the revised marketing plan must be submitted to the Department for written approval prior to engaging in any activities not specified in the original plan. The MCO marketing plan must comply with the Department Marketing Policies as described in Appendix C of this Contract.

4.1.2 Marketing Materials

Marketing and marketing materials are defined in 42 CFR §438.104(a) and in Article II, Section 1 of this contract. The MCO must follow the marketing guidelines as described in 42 CFR §438.104, this Contract and Appendix C, the Department Marketing and Member Materials Policies.

All marketing materials must be easily understood and readable at the sixth(6th) grade (Grade 6.9 or below) and must satisfy the information requirements of this Contract to ensure that before enrolling in the MCO, individuals receive accurate oral and written information needed to make an informed decision on whether to enroll. Materials must use a conspicuous font size (such as twelve (12) point), an easily readable typeface frequent headings, and must provide short, simple explanations of key concepts. Technical or legal language must be avoided whenever possible. The MCO must submit evidence to the Department that its materials satisfy this requirement[12] and provide a written assurance that marketing materials do not mislead, confuse or defraud

[12] Many commercial word processing software programs contain utilities for testing the readability of documents produced using the program.

4.2.1.3 Enrollment of Program Newborns

The MCO must have written policies and procedures for enrolling newborn children of enrollees retroactively effective to the time of birth. These enrollment procedures must include:

- Transfer of newborn information to the Department.
- Processing completion within thirty (30) calendar days of the date of birth.
- Submission of the newborn enrollment forms within sixty (60) calendar days of the date of delivery or as soon thereafter as the MCO becomes aware of the delivery. The MCO must exhaust all possible avenues to research, locate, and include on the forms the names for newborns, which will in turn help to decrease issues with missing capitation payments.

The MCO is responsible for all covered services provided under this contract to the newborn child during this time. The child's date of birth will be counted as day one (1). The Department will pay a full month's capitation for all newborns. The MCO will receive capitation payments for all subsequent months that the child remains enrolled with the MCO. The MCO must inform the CPS worker of the birth of an infant to a child in Foster Care within one (1) business day of learning of the birth.

4.2.1.4 Enrollment of Persons with Other Primary Coverage

For enrollees with other primary coverage, the MCO must assume responsibility for Medicaid covered services that are not provided by the primary carrier. The MCO will defer utilization management decisions to the primary carrier, except for those Medicaid services and benefits that are carved out of the primary carrier's benefits package, which are the sole responsibility of the MCO.

4.2.2 Assignment of Primary Care Provider

The MCO must inform each enrollee about the full panel of participating providers. To the extent possible and appropriate, the MCO must offer each enrollee covered under this Contract the opportunity to choose among participating providers at the time of enrollment. This does not preclude the MCO from assigning a PCP to an enrollee who does not choose one. The MCO may assign an enrollee to a PCP when an enrollee fails to choose one after being notified to do so. The MCO must set a period of time during which an enrollee may select a PCP, not to exceed five (5) calendar days after enrollment. Upon expiration of this time period, the MCO must assign the enrollee to a PCP. The assignment must be appropriate to the enrollee's age, sex, and residence.

The enrollee must be notified of this assignment and of the procedures for changing the designated provider. In the event that a PCP ceases to be affiliated with the MCO, the MCO's procedures must provide for notice to affected enrollees at least thirty (30) calendar days before the termination date and promptly assist enrollees in obtaining a new PCP.

4.2.3 Enrollment Limits

In accordance with 42 CFR §438.206, the Department may establish a maximum Medicaid enrollment level for Medicaid beneficiaries for the MCO on a county-specific basis dependent on the Department evaluation of the capacity of the MCO's network. Subsequent to the establishment of this limit, if the MCO wishes to change its maximum enrollment level, it must

month after the month in which the MCO requests termination. When notifying the Department of its intent to disenroll an enrollee, the MCO must specify the reason for the request in order to assure the Department that the reason for the request is consistent with the permissible reasons specified in this contract. The Department will make the final decision to approve or deny the requested MCO-initiated disenrollment. If the Department does not act on the MCO's request for a disenrollment, the disenrollment will be considered as approved.

4.2.4.2 Enrollee-Initiated Disenrollment

MCO enrollees eligible through adoption assistance may request disenrollment and return to Medicaid FFS at any time for any reason. Disenrollment will be effective no later than the first day of the second month after the month in which the enrollee requests disenrollment.

For children in foster care and adoption assistance, Medicaid beneficiaries will have a choice of one MCO or FFS in all fifty-five (55) counties in West Virginia.

Children eligible through the CSED waiver will be mandatorily enrolled in the specialized MCO with concurrent 1115 expenditure authority and will not have the option to disenroll into FFS.

If the state agency fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established had the State or MCO made a determination in the specified timeframe, consistent with 42 CFR §438.56.

4.3 Enrollee Services Department

4.3.1 General Requirements

The MCO must maintain an Enrollee Services Department to assist enrollees in obtaining Medicaid and SNS covered services. The Enrollee Services Department, at the minimum, must be accessible during regular business hours, at least for nine (9) hours a day and through a toll-free phone number. The Enrollee Services Department must work with Medicaid enrollees, CPS workers, Adoptive and Foster Care parents, parents and guardians of children with a SED and providers to handle questions and complaints and to facilitate the provision of services.

The MCO must ensure that the toll-free enrollee services phone line meets the following minimum SLAs:

1. Eighty-three percent (83%) of calls are answered live within thirty (30) seconds during operating hours. Time measured begins when the enrollee is placed in the call queue to wait to speak to an Enrollee Services representative; and
2. The call abandonment rate does not exceed five percent (5%) of total calls for the month.

The MCO must submit to BMS monthly reports outlining its performance against the above referenced measures and submit an attestation to its accuracy.

The MCO must provide training to all call center staff on all aspects relating to the Medicaid program, including but not limited to all grievances and appeals procedures consistent with Article III, Section 4.8 (Grievances and Appeals).

4. Twenty-four (24)-hour telephone number for use in urgent or emergent medical situations;
5. Telephone number for enrollee services (if different);
6. PCP name and office telephone number;
7. TTY number;
8. The secure provider portal web address; and
9. The name of the MCO program (Mountain Health Promise).

The MCO must work with providers to educate that the MCO card is not necessary at the time of visit and help to educate providers on using their enrollment portal or the WVMMIS portal to confirm eligibility of the enrollee.

4.4.3 Enrollee Handbook

The MCO must use the model enrollee handbook supplied by the Department and insert MCO-specific material as directed in the template. The MCO must use the definitions included in the model handbook in enrollee communications. BMS will review the MCO's enrollee handbook to determine whether the materials package is approved or in need of revisions.

Within five (5) business days of official enrollment notification to the MCO, the MCO must notify the new or returning enrollee's household of the availability of the enrollee handbook via:

- Electronic format available on the MCO's website;
- Email after obtaining the enrollee's agreement to receive the information by email; or
- Auxiliary aids and services upon request at no cost for enrollees with disabilities who cannot access this information online.

The MCO must provide an enrollee handbook to enrollees within five (5) business days upon request.

The MCO must review the enrollee handbook at least annually and maintain documentation verifying that the enrollee handbook is reviewed at least once a year. The MCO must provide periodic updates to the enrollee handbook as needed, and within a timeframe required by BMS, explaining changes to the MCO policies, Medicaid program, or the foster care and adoption assistance program. When there are program or service site changes, the MCO will provide notification to the affected enrollees at least thirty (30) calendar days before intended effective date of the change.

The MCO must notify its enrollees that an updated enrollee handbook is available at least annually after initial enrollment. The MCO must publish and keep current its enrollee handbook on the MCO website as specified in Article III, Section 4.4.5 of this contract.

4.4.3.1 Enrollee Handbook Requirements

The handbook must include the following information, which must adhere to the standards set forth in this contract:

1. Table of contents;

15. Explanation of emergency care, after hours care, urgent care, routine care and well-care, the process and procedure for obtaining each; and a statement that it is appropriate for an enrollee to use the 911 emergency telephone number for an emergency medical condition;
16. Explanation of what constitutes an emergency medical condition and emergency services;
17. The fact that prior authorization is not required for emergency services;
18. The enrollee's right to use any hospital or other setting for emergency care;
19. Procedures for obtaining services covered under the Medicaid State Plan or the Title IV State Plan and not covered by the MCO (e.g., prescription drugs, NEMT);
20. The extent to which and how to access post-stabilization services;
21. Limited MCO liability for services from non-MCO providers, e.g., only emergency care or referrals;
22. Information about what to do when family composition changes;
23. Appointment procedures and access standards including travel time, scheduling standards and the MCO's standard waiting time;
24. Guidance to seeking care when out-of-area services are required, including authorization requirements and process;
25. How to obtain emergency transportation, Medically Necessary transportation and non-emergency transportation;
26. How to obtain maternity and STD services;
27. How to obtain behavioral health and SUD services;
28. How to obtain CSED waiver services and choose an appropriate CSED waiver provider;
29. How to obtain non-emergency and emergency dental services;
30. Information on enrollees' rights to access certified nurse midwife services and certified pediatric or family NP services;
31. Procedures for recommending changes in policies or services;
32. What to do in the case of out-of-county and out-of-state moves;
33. What to do if the enrollee has a worker's compensation claim, pending personal injury or medical malpractice law suit, or has been involved in an auto accident;
34. Information of contributions that enrollees can make toward their own health, enrollee responsibilities, appropriate and inappropriate behavior and any other information deemed essential by the MCO or the Department;
35. Information on enrollee rights and responsibilities, as outlined in this contract and federal regulations such as 42 CFR §438.100;
36. Information on an enrollee's right to access their health information through patient access APIs, including the types of information available through the API and how to access it;

- Telephone numbers,
- Website URL, as appropriate,
- Whether the provider will accept new enrollees,
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and
- Whether the provider's office/facility has accommodations for people who have physical disabilities, including offices, exam room(s), and equipment.

At minimum, the provider directory must include the above information for all of the following MCO network providers:

- Physicians, including primary care physicians and specialists
- General pediatric dentists,
- Behavioral health providers,
- Hospitals, and
- Long-term services and supports (LTSS) providers, as applicable.

The MCO must also include the following information:

- The phone number for the twenty-four (24)-hour help line (i.e., Nurse Helpline);
- Explanation of when to call 911 for emergency care, and a statement that no referral is required to obtain services for emergency medical conditions;
- The three-digit 988 mental health crisis and suicide prevention number for call, text, and chat for use by individuals who are experiencing suicidal ideation, mental health and substance use crises, or any type of emotional distress.

The provider directory must also identify those providers that are renderers of CSED waiver services, either by separately identifying that classification of provider, or by denoting existing providers using a clearly defined symbol.

The MCO must give affected enrollees notice of any changes regarding network providers, including change in the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, and identification of providers that are not accepting new patients. Notice must be at least thirty (30) calendar days before the intended effective date of the change. The MCO shall be considered as compliant with notice requirements if correcting the provider directory maintained on the MCO's website within the required timeframe.

The MCO must update the paper provider directory at least monthly if the MCO does not have a mobile-enabled electronic directory, or quarterly if the MCO does have a mobile enabled electronic directory. Updates shall include a notice to interested parties containing information on how to access the most current provider directory information electronically via the MCO's public website and/or its publicly accessible API.

- Enrollee medical and SNS records (including assessments);
- Confirmation of services previously provided to avoid duplication; and
- Enrollee eligibility information.

4.5 Education

4.5.1 New Enrollee Orientation

The MCO must have written policies and procedures for orienting new enrollees about the following:

1. Covered Medicaid and SNS benefits;
2. The role of the PCP and how to select a PCP;
3. How to make appointments and utilize services;
4. What to do in an emergency or urgent medical situation and how to utilize services in other circumstances;
5. How to access carved-out services in the FFS system;
6. How to register a complaint or file a grievance;
7. Enrollees' rights and responsibilities; and
8. Contents of the enrollee handbook.

The MCO is required to make a best effort to contact the enrollee within forty-five (45) calendar days of the effective date of enrollment for an enrollee "welcome call." If the initial attempt to contact the enrollee is unsuccessful, the MCO must make subsequent attempts to complete the call. The MCO must document all contact efforts and make at least three (3) contact attempts at three (3) different times of day before considering the enrollee as unreachable. The MCO must establish a plan for initiatives it will conduct to outreach to enrollees and caregivers who are difficult to contact, including but not limited to, enrollees with disabilities and enrollees without telephones.

4.5.2 Health Education and Preventive Care

The MCO must provide a continuous program of general health education for disease and injury prevention and identification without cost to the enrollees. Such a program may include publications (e.g., brochures, newsletters), media (e.g., films, videotapes), presentations (e.g., seminars, lunch-and-learn sessions), and classroom instruction.

The MCO must provide programs of wellness education. Such programs may include stress management, nutritional education, prenatal care, human development, care of newborn infants and programs focused on the importance of physical activity in maintaining health. The MCO must provide tobacco cessation benefits for pregnant women, and children respectively.

The MCO is not required to provide weight management services; the MCO may provide these services as a value-added service.

Additional health education and preventive care programs may be provided that address the social and physical consequences of high-risk behaviors. Examples include programs on the prevention of HIV/AIDS, unintended pregnancy, violence, SUD, tobacco use, sun exposure and

7. Informing enrollees that complaints concerning noncompliance with the advance directive requirements may be filed with the Department survey and certification office.

For further information regarding advance directives, refer to 42 U.S.C. Section 1396a (w).

4.6 Enrollee Rights

4.6.1 Written Policies on Enrollee Rights

The MCO must have written policies with respect to the enrollee rights specified below. The MCO must comply with any applicable Federal and State laws that pertain to enrollee rights. The MCO must articulate enrollees' rights, promote the exercise of those rights, and ensure that its staff and affiliated providers protect and take the rights into account when furnishing services to enrollees. The MCO must ensure that these rights are communicated to enrollees annually following initial enrollment; and to the MCO's staff and affiliated providers, at the time of initial employment or affiliation and annually thereafter. The MCO must also monitor and promote compliance with the policies by the MCO's staff and affiliated providers through analysis of complaints or grievances, requests to change providers, enrollee satisfaction surveys, and other sources of enrollee input. The MCO shall provide a copy of the Notice of Action to enrollees to help better understand the differences between complaints, grievances, appeals, and state fair hearings.

4.6.2 Specification of Rights

Each enrollee has a right:

- To receive information in accordance with the standards set forth in this contract;
- To be treated with respect and due consideration of his or her dignity and privacy;
- To accessible services;
- To choose providers from among those affiliated with the MCO;
- To participate in decision-making regarding his or her health care, including the right to refuse treatment;
- To receive information on available treatment options or alternative courses of care, presented in a manner appropriate to the enrollee's condition and ability to understand;
- To request and receive his or her medical records, and to request that they be amended or corrected, for which the MCO will take action in a timely manner of no later than thirty (30) calendar days from receipt of a request for records, and no later than sixty (60) calendar days from the receipt of a request for amendments, in accordance with the privacy rule as set forth in 45 CFR parts §164.524 and §164.526, upon their effective dates, to the extent they apply;
- To obtain a prompt resolution of issues raised by the enrollee, including complaints, grievances, or appeals and issues relating to authorization, coverage, or payment of services;
- To access their health information through the use of APIs in accordance with the requirements set forth by 42 CFR §431.60 and §438.242;
- To offer suggestions for changes in policies and procedures;

and concerning the MCO's policies with respect to the implementation of such rights (this information must be included in the enrollee handbook);

- Documenting in the enrollee's medical record whether or not the enrollee has executed an advanced directive;
- Not conditioning the provision of care or otherwise discriminating against an enrollee based on whether the enrollee has executed an advance directive;
- Ensuring compliance with requirements of state law respecting advance directives; and
- Providing education for staff and the community on issues concerning advance directives.

The MCO may not prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future decisions.

4.7 Enabling Services

The MCO must ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities. The MCO shall provide enabling services, including but not limited to, assistance with complaints, grievances, and appeals to enrollees with physical or developmental disabilities.

4.7.1 Communication Barriers

The MCO is required to provide oral interpretive services for languages on an as-needed basis. These requirements extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the MCO and providers and receive coverage benefits. Oral interpretative services must be provided free of charge to enrollees and potential enrollees and must be available for all non-English languages. The MCO must also provide audiotapes for the illiterate upon request.

The Department will periodically review the degree to which there are any prevalent language or languages spoken by Medicaid beneficiaries in West Virginia (cultural groups that represent at least five percent (5%) of the Medicaid population). Within ninety (90) calendar days of notification from the Department, the MCO will make written materials available in prevalent non-English languages. At the current time, there is no data to indicate that West Virginia has any Medicaid populations that meet this definition.

The MCO must notify enrollees and potential enrollees of the availability of oral interpretation services for any language and written materials in prevalent non-English languages. The MCO must also notify enrollees and potential enrollees of how to access such services.

4.7.2 Sensory Impairments

The MCO must develop appropriate methods for communicating with its visually- and hearing-impaired enrollees and accommodating the physically disabled. The MCO must have TDD services available. MCO enrollees must be offered standard materials, such as enrollee

the same information pertaining to the MCO's grievance, appeal and fair hearing procedures as was provided to enrollees;

2. Provide an address for written appeals and formal grievances;
3. Designate at least one (1) grievance coordinator;
4. Allow an eligible enrollee to file a grievance at any time;
5. Permit that both grievances and appeals can be filed orally or in writing;
6. Offer to meet with the enrollee during the grievance process;
7. With written consent from the enrollee, allow for a provider or authorized representative to file a grievance, appeal, or request a State Fair Hearing on behalf of the enrollee;
8. Information about the peer-to-peer consultation process for providers who request consultation for a prior authorization request that is rejected. The process must be in accordance with West Virginia Code § 33-25A-8s;
9. No punitive action may be taken against a provider who files an appeal on behalf of an enrollee or supports the enrollee's appeal;
10. A detailed description of the MCO's enrollee grievance and appeal procedure including the enrollee's ability to request continuation of benefits while the MCO appeal and the State fair hearing are pending must be included in the enrollee handbook provided to enrollees;
11. Require the MCO to provide reasonable assistance in completing the procedure, including but not limited to completing forms, auxiliary aids and services, and toll-free phone numbers with adequate TTY/TDD and interpreter capability as specified by the MCO;
12. Acknowledge receipt of grievances and appeals;
13. Involve some person with problem solving authority at each level of the procedures, including ensuring that:
    a. Individuals, or their subordinates, reviewing and making decisions on grievances and appeals were not previously involved in decisions related to the grievance or appeal under review;
    b. Individuals reviewing and making decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether the information was submitted or considered in the initial adverse benefit determination; and
    c. Individuals reviewing medically related grievances or denials of expedited resolution of an appeal have appropriate clinical expertise, as determined by the State in treating the enrollee's condition or disease.

The MCO must provide enrollees with an opportunity to present in writing or orally, evidence and allegations of fact or law; the opportunity to examine his or her case file free of charge, including medical records, before and during the grievance or appeal as well as other documents considered during the appeal. Parties to the appeal must include the enrollee, his representative,

days from the date of the request by a provider for the consultation. The MCO must make a decision about the appeal of a prior authorization decision within ten (10) business days from the date of the appeal submission; and

6. If the timeframe for resolving an appeal is extended for any reason other than an enrollee request, the MCO must give the enrollee written notice of the reason for the delay within two (2) calendar days and make reasonable efforts to give the enrollee prompt oral notice of the delay. The MCO must resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. The MCO must inform the enrollee or his representative of the right to file a grievance if he or she disagrees with that decision.

The MCO must provide written notice of the disposition of appeals which will include: the result, the date of the resolution, the right and procedure to request a state fair hearing, the right to receive continuation of benefits while the hearing is pending, how to make the request for continuation of benefits, and potential enrollee liability for the cost of continuation benefits if the state fair hearing upholds the MCOs decision. The MCO must ensure that if the MCO fails to adhere to notice and timing requirements, the enrollee is deemed to have exhausted the MCO's appeals process and the enrollee may initiate a State Fair Hearing.

4.8.2 Enrollee Expedited Appeals

4.8.2.1 Enrollee Expedited Appeals: Process

The MCO must establish and maintain a process for the review and resolution of requests for an expedited appeal process regarding any denial, termination, or reduction of Medicaid or SNS covered services, which could seriously jeopardize the enrollee's health and well-being. This includes an appeal regarding any service related to an enrollee's formal treatment plan as developed by the MCO and PCP. The expedited process for appeals must meet the grievance and appeal general requirements set forth in the prior subsections and provide that:

1. Expedited review of appeals is available upon request of the enrollee, authorized representative, or provider if the MCO determines that the timeframe for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function;
2. Allow that the MCO will not be penalized for allowing an authorized representative or providers to file an expedited appeal on behalf of enrollees with the enrollee's written consent; and
3. The MCO inform the enrollee or his or her representative of the limited time available to present in writing or orally, evidence and allegations of fact or law;

4.8.2.2 Enrollee Expedited Appeals: Resolution Timeframes

The MCO must address timeframes specific to resolution of enrollee expedited appeals in its process including, but not limited to, the following:

1. If a request for an expedited appeal in denied, the MCO must transfer the appeal to the standard resolution timeframe and make reasonable effort, as defined by the Department, to provide prompt oral notice to the enrollee, his or her representative, or provider, followed up with written notice within two (2) calendar days, and resolve the appeal as

i. The MCO has evidence of the enrollee's death or that the enrollee no longer wishes services, has provided information that requires termination or reduction of services and understands the result of providing such information; has been admitted to an institution and is therefore no longer eligible under the plan; has been accepted for Medicaid services in another State, territory or Commonwealth;

ii. The enrollee's whereabouts are unknown, and the post office returns the enrollee's mail indicating no forwarding address;

iii. The enrollee's physician has changed the level of care (LOC) prescribed;

iv. The notice involved an adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989;

v. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse benefit determinations for NF transfers); or

vi. The date of adverse benefit determination will occur in less than ten (10) calendar days in accordance with 42 CFR §438.12.

c. For adverse benefit determinations due to probable fraud by the enrollee, no later than five (5) calendar days in advance of the action;

d. For denial of payment, at the time of any adverse benefit determination affecting the claim;

e. Within fourteen (14) calendar days of the request for services when services under a standard service authorization decision are being denied or limited;

f. If the MCO extends the period for making standard authorization decisions in accordance with this contract, and must inform the enrollee of his right to file a grievance regarding the decision;

g. On the date the timeframes specified in this Contract expires, if those timeframes are not met; and

h. Within seventy-two (72) hours after the receipt of a request for an expedited authorization.

4.8.4 Review of Appeal Decisions

None of the foregoing procedures precludes the right of enrollees to request a fair hearing before the Department of Human Services as part of an enrollee's right to fair hearing related to applications for eligibility and decisions to suspend, terminate, or reduce services as specified in 42 CFR §431.220 and 42 CFR §438.400. The MCO must implement any decision made by the Department pursuant to such a review. Enrollees must exhaust all MCO grievance and appeals procedures and receive notice that the MCO is upholding the adverse benefit determination prior to requesting a state fair hearing. The enrollee or his representative must request a state fair hearing no later than one hundred twenty (120) calendar days from the date of the MCO's notice of resolution.

authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services in accordance with the Department policy and regulations. However, if the final resolution of the appeal or state fair hearing is adverse to the enrollee, the MCO may recover the cost of services furnished to the enrollee while the appeal and state fair hearing were pending, to the extent that they were furnished solely because of the requirements of this section.

Pursuant to W.Va. Code § 9-2-13, any party adversely affected or aggrieved by a final decision or order may seek judicial review of that decision by filing a petition with the required parties within thirty (30) days after the date upon receipt of notice of the final order or decision. BMS shall notify the MCO of action to appeal the adverse fair hearing decision.

The MCO must resolve at least ninety-eight percent (98%) of enrollee appeals within thirty (30) calendar days from the date the appeal is filed with the MCO, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee.

4.9 Cost-Sharing Obligations

The MCO, through the MCO's providers, must impose copayments for covered services in the amounts that are determined by the Department in accordance with the requirements specified in the Medicaid State Plan and the requirements set forth in 42 CFR §447.50 - §447.82.

The MCO shall have claims processing guidelines and systems requirements that address co-payment or cost-sharing obligations by enrollee/population and covered services. The MCO must reduce payments to the network providers by the amount of the enrollee's copay, regardless of whether the provider successfully collects the copay. The MCO, or the MCO's providers, may not routinely waive required copays.

The MCO must have a process to track a quarterly household maximum for the cost-sharing obligations based on the enrollees' Federal Poverty Level (FPL).

4.9.1 Services and Enrollees Exempt from Cost-Sharing Obligations

The MCO and the MCO's providers may not charge copays to the following MCO enrollees or on the following services:

1. Family planning services;
2. Emergency services;
3. Behavioral Health services;
4. Enrollees up to age twenty-six (26);
5. Pregnant women (including the twelve (12) month postpartum period following the end of pregnancy);
6. American Indians and Alaska Natives;
7. Enrollees receiving hospice care;
8. Enrollees in nursing homes;
9. Any additional enrollees or services excluded under the State Plan authority; and
10. Enrollees who have met their household maximum limit for the cost-sharing obligations per calendar quarter.

2. Identify the category, group, or managed care program of enrollees eligible to receive the proposed Value-Added Service if it is a type of service that is not appropriate for all enrollees;
3. Identify the providers or entities responsible for providing the Value-Added Service;
4. Note any limitations or restrictions that apply to the Value-Added Service. For approved Value-Added Services, the MCO must include a disclaimer in its marketing materials and provider directory indicating restrictions and limitations may apply;
5. Indicate how and when the MCO will notify providers and enrollees about the availability of the Value-Added Services, including information about the type and frequency of communications;
6. Indicate the time period during which the Value-Added Services will be offered and how the MCO will notify providers and enrollees when the service is no longer available through the MCO;
7. Provide proposed data for which the MCO will submit quarterly reports to the Department specific to the Value-Added Service as specified below; and
8. Describe how the MCO will identify the Value-Added Service in the encounter data and/or in its financial reports, as applicable.

The MCO must track and report on the Value-Added Services that it offers to enrollees. The MCO must submit quarterly reporting to the Department that provides information such as the following and as applicable to each Value-Added Service: number of requests for approval, number of enrollees who received the Value-Added Services, percent of requests for approval that were denied and rationale for denial.

Since Value-Added Services are not Medicaid covered services or required SNS, there is no appeal or fair hearing rights for an enrollee regarding these services. A denial of a Value-Added Service will not be considered an adverse benefit determination. The MCO must notify an enrollee if a Value-Added Service is not approved. No-copays may be imposed for the Value-Added Services.

4.11 Population Health

The MCOs shall participate in, and support, BMS's efforts to address population health and eliminate health disparities in West Virginia. According to the U.S. DHHS, and for the purposes of this Contract, a health disparity is "a particular type of health difference closely linked with social, economic, and/or environmental disadvantage."[14] Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (i.e. race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive; sensory or physical disability; sexual orientation; or geographic location).

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[14] "Disparities", the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities#:~:text=Healthy%20People%202020%20defines%20a,%2C%20and%2For%20environmental%20disadvantage.

4. Plan for incorporating SDoH strategies into the MCO's overall QAPI by:
    a. Linking enrollees to identified SDoH needs; and
    b. Providing relevant SDoH value-added services offerings;
5. Description of how the MCO will directly address and adapt its QAPI to accommodate SDoH needs for the following target populations:
    a. CSHCN, enrollees with expanded health care needs, and adults with special health care needed to include enrollees for whom social needs have been identified through CSHCN providers or through the enrollee's health risks assessment;
    b. Enrollees who have been identified as having select risk factors through the MCO's coordination of care programs that promote community integration as set forth in Article III, Section 6.3.3.5; and
    c. Other populations with complex physical, behavioral, and social conditions.

The MCO shall monitor, promote, and educate provider use of SDoH ICD-10 codes (Z55-Z65) on claims to support data collection on the social risk factors of health experienced by enrollees.

4.11.1.2 Assessment of SDoH Needs

The MCO shall screen enrollees for SDoH risk factors and properly refer enrollees to community-based resources based on assessed need. Enrollees must be screened during the initial health risk assessment and then annually to reassess SDoH needs past initial enrollment.

The MCO's care coordination efforts shall address SDoH that identify and address enrollee access, which includes, but is not limited to: (1) employment; (2) food security; (3) housing stability; (4) resources that connects enrollees to social supports and healthcare; and (5) transportation. Care coordination and care management assessments and reassessments must also address SDoH and any needs shall be documented in care plans. The SDoH screening and referral process shall include, but not be limited to aspects such as enrollee housing and utilities status, food insecurity, transportation availability, and employment status.

If the MCO identifies any SDoH needs and refers enrollees to external entities (e.g., community-based organizations [CBOs], local non-profits), it must follow up with enrollees to document the completion of enrollee's referral and the successful provision of services. The MCO will ensure that SDoH needs are addressed in culturally appropriate ways, with accessibility to all resources and services rendered.

4.11.1.3 MCO Staff and Training Requirements

The MCO staff (including care management and enrollee services staff) shall receive training in the following areas:

- Specific training on care coordination job functions with an annual refresher training on motivational interviewing;
- Bi-annual training on cultural competency and implicit bias;
- Annual training on customer service;

- Number of enrollees receiving additional support services from community health workers and/or patient navigators
- Number of enrollees enrolled in health promotion and prevention programs delivered by a CBO.

The MCO shall have a process to collect and maintain enrollee demographic, SDoH, and health assessment data for aggregate use in population health management, network adequacy determination, and quality improvement activities. Within that process, the MCO shall describe how it will collect data to inform its programs for coordination of care and partnerships with community resources and social services for enrollees.

5. MEDICAID ADMINISTRATOR/CONTRACT LIAISON FUNCTIONS

The MCO must employ a West Virginia Medicaid Administrator/Contract Liaison. The MCO's Medicaid Administrator(s) may also fulfill the duties of the Contract liaison, as outlined in Article II, Section 5.9 of the Contract. The Medicaid Administrator(s) must be responsible for making recommendations to management on any changes needed to improve either the actual care provided or the manner in which the care is delivered.

The person(s) must be in a position within the MCO that provides the authority needed to carry out these tasks and must be authorized and empowered to make and resolve operational and policy decisions within two (2) business days and financial decisions pertaining to claims payment issues within five (5) business days. The person(s) must demonstrate substantial experience in health care, experience working with low-income and foster care populations and cultural sensitivity. The person(s) serving as Medicaid Administrator(s) must be dedicated full-time to this function. The Administrator(s) need not be located full-time in West Virginia, but must be accessible through an 800 number and must be available in West Virginia as required. If the Administrator(s) are out of the office, there must be a designee available who can respond to the Administrator's duties within the required timeframe. The Administrator(s) will:

1. Investigate and resolve access and cultural sensitivity issues identified by MCO staff, State staff, providers, advocate organizations and beneficiaries;
2. Monitor MCO grievances with the grievance personnel to look at trends or major areas of concern and discuss these reports with community advocates, if requested;
3. Coordinate with local Departments of Human Services, schools, community agencies, local health departments, state health laboratories and state agencies providing complementary services to Medicaid enrollees;
4. Recommend policy and procedural changes to MCO management including those needed to ensure and improve enrollee access to care and quality of care; changes can be recommended for both internal administrative policies and providers;
5. Function as a primary contact for beneficiary advocacy groups and work with these groups to identify and correct beneficiary access barriers;
6. Connect with local community organizations to acquire knowledge and insight regarding the special health care needs of beneficiaries;
7. Analyze systems functions through meetings with staff;

3. MCO's risk stratification framework, including the criteria and threshold for identification and assignment of enrollee's to each risk level, and the process for adjusting risk level when an enrollee's needs change;
4. Assignment of MCO care coordination staff, including caseloads by risk stratification and assignment methodology. The MCO should use care coordinators as appropriate, (e.g., experienced pediatric nurses and behavioral health specialists) ;
5. Processes to structure the care management system to serve the complex physical health and behavioral health needs of enrollees;
6. Strategies to address SDoH and racial and ethnic disparities in healthcare;
7. Assignment of MCO care coordination staff, including caseloads by risk stratification and assignment methodology;
8. MCO's requirements related to required periodic ESPDT schedules;
9. MCO's roles and responsibilities to support Care Coordination Entities (CCEs) in providing care coordination to the MCO's enrollees and ensuring the enrollees' needs are met;
10. MCO's roles and responsibilities for performing care coordination activities when the MCO is exclusively providing care coordination to enrollees;
11. How the MCO will notify enrollees of care coordination assignment;
12. How often the coordinators contact enrollees after initial care coordination contact based on the enrollee's acuity level;
13. MCO's data and information systems and how they will be used to support MCO's responsibilities for care coordination regardless of which entities are providing care coordination;
14. MCO's process for the electronic exchange of enrollee health information with its providers, contractors, and other MCOs, including at a minimum, details on the MCO's implementation of and compliance with the standards set forth by 45 CFR parts § 170.205 and § 170.213; and
15. How the MCO will monitor the care coordination program for individual and systemic improvements, including a process for management-level monitoring and evaluation of care coordinators and care managers in establishing relationships with enrollees, including but not limited to, statistics collected and frequency of collection (e.g., for completion of care plans).

The MCO must have a documented procedure to:

1. Ensure the services that the MCO provides to the enrollee are integrated with any services provided by other entities and to promote case management;
2. Ensure a comprehensive care management approach is applied; and
3. Communicate clinical and other pertinent information among providers in a timely manner for efficient treatment and follow up.

3. Systems to assure provision of care in emergency situations, including an education process to help assure that enrollees know where and how to obtain Medically Necessary care in emergency situations;
4. A system by which enrollees may obtain a covered service or services that the MCO does not provide or for which the MCO does not arrange because it would violate a religious or moral teaching of the religious institution or organization by which the MCO is owned, controlled, sponsored or affiliated;
5. Coordination and provision of EPSDT services as defined in Article III, Section 2.2;
6. Policies and procedures that ensure the completeness of the case management record to include all results of referrals, consultations, inpatient records, and outpatient records; and
7. Procedures to share, with the State or other MCOs serving the enrollee, the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities.

In accordance with 42 CFR §438.208(c)(2), the MCO must implement mechanisms to assess each Medicaid enrollee in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

The MCO must establish and operate an integrated Population Health Program based upon risk stratification of the MCO population. The Population Health Model supports enrollees across the entire care continuum, promoting healthy behaviors and disease self-management as well as providing care coordination and intense care management as needed and supported by evidence-based medicine and national best practices.

The MCO must have a risk stratification framework to review the enrollee's health risk assessment and other available information and to facilitate assignment of enrollees to the three (3) risk levels set forth below, according to criteria and thresholds for each level. Criteria and thresholds must include current and historical factors including, but not be limited to:

1. Acuity of chronic conditions;
2. Behavioral health and SUDs;
3. Prenatal risk for mother and baby (e.g., prior pre-term birth);
4. Justice-involved;
5. Inpatient or emergency department utilization;
6. SDoH; and
7. Safety risk factors.

The MCO must evaluate the entire enrollee population and identify enrollees for specific programs according to risk rather than disease specific categories. This approach shall include the following risk levels and programs:

- Risk Level 0: Wellness Program

caseworker and placement provider on all referrals for placement, and conducting referral follow-up to assist with securing the placement.

The MCO must 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, reduce duplication of services, and improve access to service needs; and
- Applicable state foster care advocacy groups, the foster care ombudsman, and Court-Appointed Special Advocates (CASAs).

The MCO must establish relationships and collaborate with the enrollee's community resources in an effort to facilitate access to services, reduce duplication, and ensure appropriate placement needs are met. The MCO must establish a process that outlines how the MCO will assist in preventing movement to higher levels of care through collaboration with entities including:

- Community resources;
- Child Protective Services (CPS), psychiatric residential treatment facilities (PRTFs), residential providers, and behavioral health providers; and
- Key community partners that provide case management, case planning, and permanency planning.

The MCO must develop a process subject to Department approval to identify and manage the care of enrollees who are transferring from juvenile justice facilities to foster care placements.

For enrollees referred to PRTF services, the MCO shall establish an internal committee comprised of physicians and enrollees of the Department to determine if placement is most appropriate to meet the needs of the youth, or if outpatient and community-based resources can be established to meet the needs of the youth. The MCO shall also be required to implement a systematic administrative process to coordinate access to services, including non-capitated services, such as wraparound services or other programs offered by the Department to help keep the enrollee in their home and reduce residential placements. The MCO must coordinate with the Department to identify important resources to help enrollees in maintaining health and well-being.

The MCO must have a comprehensive written assessment procedure for enrollees accessing PRTF-levels of care, including development of a discharge plan. Each enrollee that enters a PRTF must have a thorough assessment completed by the provider, a subsequent plan of care, and a written discharge plan. The MCO must evaluate and prepare an enrollee for discharge through the following mechanisms:

1. Coordinate with the psychiatric residential treatment providers, treating professionals and the enrollee or guardian to plan enrollee's care and discharge;
2. Coordinate with the Department on Medicaid and non-Medicaid services, to be provided to the enrollee to help keep the enrollee in their setting of choice, as appropriate;
3. Coordinate community resources upon discharge;

1. Identifying enrollees who require assistance transitioning between inpatient settings to outpatient/home settings;
2. Communicating with the discharging facility and participation in discharge planning activities with the facility;
3. A method for evaluating risk of readmission or deterioration to determine the intensity of follow up required for the enrollee after the date of discharge;
4. Confirming that services are authorized and delivered in accordance with the discharge/ transition plan;
5. Timely follow-up with the enrollee and the enrollee's PCP to help ensure post-discharge services have been provided; and
6. Improving performance of network providers that improves post-discharge planning and the provision of care coordination services post-discharge.

As part of discharge planning, the MCO must make all reasonable effort (the MCO must make at least three (3) contact attempts at three different times of day) to engage any enrollee exiting a drug rehabilitation program to determine whether employment assistance or other support is needed. If so, the MCO must coordinate a referral to a local workforce agency and facilitate linkages to other related community supports available. If the enrollee is unable to be reached during the discharge planning process, the MCO must engage the inpatient facility case worker to coordinate for discharge supports.

The MCO's notice to an enrollee and/or provider of its decision to deny, limit, or discontinue authorization of, or payment for, a service as a result of care coordination decisions as discussed in this subparagraph must specify the criteria used in denying or limiting authorization and include information on how to request and appeal or grievance of the decision pursuant to the procedures required in this Contract. The notice to the enrollee must be in writing.

6.3.3 Coordination of Care with Other Entities

6.3.3.1 Family Planning

Family planning services will be tracked, coordinated and monitored by the MCO. The MCO will assume one hundred percent (100%) financial risk for these services. BMS will not be responsible for any lapse in reimbursement for family planning services. Through its reimbursement of other providers, the MCO will be able to monitor enrollees' utilization of such services. Additionally, the MCO will ask in-network providers to educate enrollees about the release of necessary medical data to the MCO.

The MCO must ensure that enrollees who seek family planning services from the plan are provided with counseling regarding methods of contraception; HIV and STDs and risk-reduction practices; and options to pregnant enrollees who may wish to terminate their pregnancies. The MCO will make appropriate referrals as necessary. All family planning services will be included in the encounter data that all health plans must report to the Department.

Pursuant to West Virginia Code §16-2B-1, the MCO shall not require multiple office visits or prior authorizations for a woman who selects long-acting reversible contraceptive (LARC) methods unless Medically Necessary. The MCO shall provide payment for LARC devices and their insertion, maintenance, removal, and replacement. The MCO may not present barriers that

specialists caring for the enrollee. The treatment plan must meet applicable quality assurance and utilization standards. In accordance with 42 CFR §438.208(c)(3), these treatment plans must be reviewed and revised upon reassessment of functional need, at least every twelve (12) months, when the enrollee's circumstances or needs change significantly, or at the request of the enrollee.

In accordance with 42 CFR §438.208(c)(4), if a treatment plan or regular care monitoring is in place, the MCO must have a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

The MCO must share the identified needs and the MCO's assessment of enrollees with special health care needs with other entities serving those enrollees as appropriate to coordinate care. The MCO must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the requirements of 42 CFR parts 160 and 164 subparts A and E, to the extent they apply.

The MCO must have trained staff available to assist in the development of a clinical treatment plan and to work with the enrollee and PCP to facilitate specialty referrals, coordinate SNS, hospital admission/discharge planning, post-discharge care and continued services (e.g., rehabilitation), and to coordinate with services provided on a FFS basis.

6.3.4.1 Care Coordination with the Title V State Agency

The MCO, through the Department, will coordinate with the Bureau for Public Health (BPH), Office of Maternal, Child and Family Health (OMCFH), to:

1. Make all reasonable efforts to assure that all enrollees with special health care needs, ages zero (0) to twenty-one (21), have access to a medical home and receive comprehensive, coordinated services, and supports pursuant to national standards for systems of care for children and youth with special health care needs;
2. Make all reasonable efforts to assure appropriate access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT;
3. Improve the rates and content of well child visits;
4. Improve care coordination for children with special health care needs, particularly those with multiple systems of care in place;
5. Make all reasonable efforts to assure children enrolled in Medicaid and their established plans of care are being met.

The Department, BPH, OMCFH, and the MCO will establish a Memorandum of Understanding (MOU) to implement coordination strategies to better serve children under the age of twenty-one (21), including those individuals with special health care needs, who are eligible for Medicaid managed care services. The MCO must collaborate with OMCFH care coordinators to share plans of care for children with special health care needs. The MCO must ensure that they do not duplicate services provided by OMCFH.

The MCO and OMCFH must share data necessary to improve service delivery and improved outcomes. Each entity must designate an individual to accept and coordinate all data requests. Use of individually identifiable or personal health information MCO data will be limited to purposes directly connected to the purposes of rendering Medicaid services. All shared data will be subject to all applicable requirements regarding privacy and confidentiality and will be

6.3.7 Transition of Care

In accordance with 42 C.F.R. § 438.62(b), the MCO must have a transition of care policy to ensure continued access to physical health, behavioral health, dental, vision, and pharmacy services during a transition from FFS to a MCO, transition from one MCO to another, or between settings of care when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The MCO's transition of care policy must, at a minimum, meet BMS's defined transition of care policy and be in compliance with Federal requirements as specified in 42 CFR §438.62 (b). The MCO's transition of care policy must ensure compliance with 42 C.F.R. § 438.62(b)(1)(vi) regarding the process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 C.F.R. §170.213 (see Article III, Section 6.10, Reporting Requirements for more detail). The MCO is required to identify and facilitate transitions for enrollees that are moving from one MCO to another MCO or from the MCO to FFS or to private insurance and require additional or distinctive assistance during a period of transition. The MCO must provide an enrollee care plan to the next provider of services (e.g., new MCO, parent, or provider) within fourteen (14) calendar days of their eligibility termination with the specialized MCO.

When relinquishing enrollees, the MCO must cooperate with the receiving MCO or FFS program or private insurance plan regarding the course of on-going care with a specialist or other provider. Priority will be given (in no specific order) to enrollees who have medical conditions or circumstances such as enrollee who:

1. Are currently hospitalized;
2. Are pregnant with high-risk pregnancies in their third trimester, or are within thirty (30) calendar days of their anticipated delivery date;
3. Are in the process of donating or receiving a major organ or tissue transplantation service or which have been authorized;
4. Have a chronic illness, which has placed the enrollee in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities;
5. Are in treatment such as chemotherapy, radiation therapy, or dialysis;
6. Have ongoing special health care needs such as specialized durable medical equipment (DME), including ventilators and other respiratory assistance equipment; and
7. Are currently receiving home health services.

The MCO shall have a process for transferring enrollee information when an enrollee is transitioning to MHT, which includes, but is not limited to the following: authorization data; medical history; claims history; medical records; care management risk tier; and other patient information.

The MCO must 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.

The enrollee must have access to services consistent with the access they previously had under the enrollee's previous MCO or FFS program, and is permitted to retain their current provider for

6.3.8.1 Residential Discharge Planning

The MCO must have a comprehensive written assessment procedure for members entering the residential care. Each member that enters residential treatment must have a thorough assessment, a subsequent plan of care, and a written discharge plan. The MCO must evaluate and prepare a member for discharge thorough the following mechanisms:

1. Coordinate with the residential providers and treating professionals to plan member's care and discharge in accordance with W. Va. Code R. § 78-3-13;
2. Coordinate with BSS and child protective services for family placement and visitations;
3. Coordinate court ordered services;
4. Coordinate community resources for placement and aftercare upon a positive discharge into a non-residential setting; and
5. Coordinate with non-residential providers to deliver MCO-covered services.

The MCO must ensure that the member in residential setting is discharged into the appropriate non-residential setting of care as soon as the medically necessary criteria for such discharge are met, but no later than the fifteenth (15th) day of the following month such criteria were met, unless otherwise ordered by court.

If MCO member has not been discharged into the appropriate non-residential setting after the fifteenth (15th) day of the following month after discharge criteria were met, the Department will suspend capitation payments for that member as a specific contractual remedy. Capitation payments' suspension will continue until member is discharged appropriately. MCO may not interrupt covered services to the member during the time the Department suspends MCO capitation payments. In addition to specific remedy outlined above, the Department may impose damages as outlined in Appendix F of this Contract.

6.4 Service Authorization (Prior Authorization)

The MCO must adopt service authorization requirements that comply with State and Federal laws governing authorization of health care services, including, but not limited to, West Virginia Code §33-25A-8s and requirements for parity in mental health and SUD benefits in 42 CFR § 438.910(d). In accordance with 42 CFR § 438.210(b), the MCO and any applicable Subcontractors. The MCO must develop, maintain, and implement written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. The policies must provide for consultation with the requesting provider when appropriate and must have mechanisms to ensure consistent application of review criteria and compatible decisions. The policies must specify information sources and the process used to review, approve, or deny the provision of medical services. The MCO must notify providers and/or enrollees regarding expiration of existing medical, behavioral, pharmacy (when applicable), and SNS authorizations. The plan must have mechanisms to detect both underutilization and over-utilization of services and share monitoring and strategies with BMS upon request. Criteria for decisions on coverage and medical necessity must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals, and regularly updated. In accordance with 42 CFR §438.210(a)(3)(i), the MCO must ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

The MCO must 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. This two (2) day business period may be extended up to forty-eight (48) additional hours for expedited preservice authorizations and up to seventy-two (72) hours for expedited concurrent reviews upon request of the enrollee or if the MCO justifies to the Department in advance and in writing a need for additional information and that the enrollee will benefit from such extension.

If the MCO places authorization requirements on DME or other services necessary for an enrollee to be discharged from an inpatient stay, the MCO must provide a process for review of the service request within two (2) business days so as not to delay the enrollee's discharge. The MCO is prohibited from placing prior authorization requirements on oxygen concentrators.

The MCO must establish a peer-to-peer consultation process for rejected prior authorization requests in accordance with West Virginia Code § 33-25A-8s. The MCO must complete the peer-to-peer appeal process within five (5) business days from the date of the request by a provider for the consultation. The MCO must make a decision about the appeal of a prior authorization decision within ten (10) business days from the date of the appeal submission.

In accordance with 42 CFR §438.210(e), the MCO may not structure compensation to persons or organizations conducting utilization management activities so as to provide inappropriate incentives for denial, limitation, or discontinuation of authorization of Medically Necessary covered services.

The standards in this subsection are designed to be guidelines consistent with best practices and W. Va. §33-25A-8s. In the event that there is a conflict between this contract and the standards in W. Va. §33-25A-8s, the standards in the West Virginia Code control.

6.4.1 Service Authorization Continuity of Care

The MCO must ensure that the care of enrollees is not disrupted or interrupted. The MCO cannot require service authorization as a condition for payment for emergency care. The MCO cannot require service authorization for family planning services whether rendered by a network or out-of-network provider.

The MCO must provide a thirty (30) calendar day notice to providers before implementing changes to policies and procedures affecting the service authorization process. However, in the case of suspected FWA by a single provider, the MCO may implement changes to policies and procedures affecting the service authorization process without the required notice period.

The MCO must establish a process by which it obtains authorization and claims data from the enrollee's previous Medicaid provider to prevent access to care issues. The MCO must outline this process as an operational procedure document and submit to the Department for review and approval annually by July 1. For new enrollees, the MCO must allow the enrollee to continue to see existing providers for at least ninety (90) days as a transition of care policy.

In the event of documentation submission by a provider, placement agent, caseworker, enrollee or other third-party representative of the existence of a service authorization, the MCO must ensure enrollees receiving services through a service authorization from either another MCO or

chooses not to join the network, or does not meet the necessary qualifications to join, the enrollee will be transitioned to a participating provider within ninety (90) calendar days of enrollment, after being given an opportunity to select a participating provider.

6.6 Utilization Management

The MCO must develop and implement written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. Policies and procedures must satisfy the requirements for standard and expedited authorization of services, authorization criteria, and notice. The MCO must meet the Department-specified standards for utilization management (service authorization) listed in this contract.

The MCO shall perform ongoing monitoring of ER usage, including, but not limited to, identifying non-emergent use of the ER. The MCO should address non-emergent ER utilization through methods that include, but are not limited to, providing education to enrollees on urgent and emergent care utilization, removing barriers to care, and assisting enrollees to access routine and urgent care services.

For enrollees who have primary insurance coverage from a source other than Medicaid, the MCO must honor coverage and utilization management decisions made by the primary carrier for those services in the primary carrier's benefits package. If the MCO is responsible for Medicaid services that are carved out of the primary carrier's benefit package, the MCO has utilization management responsibility for those carved out services.

6.7 Practice Guidelines and New Medical Technology

Pursuant to 42 C.F.R. §438.236, the MCO must adopt and disseminate practice guidelines that are based on valid and reliable medical evidence or a consensus of health care professionals in the particular field, consider the needs of the enrolled population, are developed in consultation with network providers, and are reviewed and updated periodically. The guidelines must be disseminated to all affected providers and, upon request, to enrollees and potential enrollees. The MCO must ensure that decisions with respect to utilization management, enrollee education, coverage of services, and other areas to which the guidelines are applicable are consistent with the practice guidelines. Practice guidelines must be made available to the Department upon request for review within two (2) business days of the request.

The MCO must develop and implement written policies and procedures for evaluating new medical technologies and new uses of existing technologies.

6.8 Enrollee Medical Records and Communication of Clinical Information

In accordance with 42 CFR §438.242(c), the MCO must compile and maintain, in a centralized database, encounter-level data on all Medicaid services provided under this contract and rendered by individual providers to enrollees and submit this information to the Department. The MCO must submit enrollee encounter data to BMS at a frequency and level of detail as requested by CMS and BMS, based on program administration, oversight, and program integrity needs, including member encounter data that BMS is required to report to CMS under 42 CFR §438.818. Encounter data must be submitted in the standardized ASC X12N 837 and NCPCP formats, and the ASC X12N 835 format as appropriate.

explicit notation in the record and follow-up plans for significantly abnormal lab and imaging study results;

14. Emergency care;
15. Hospital discharge summaries: all hospital admissions which occur while the patient is enrolled in the plan, and prior admissions as necessary;
16. Advance directives: documentation of whether or not the individual has executed an advance directive;
17. Patient visit data: documentation of individual encounters must provide adequate evidence of, at a minimum:
    - History and physical examination, including appropriate subjective and objective information is obtained for the presenting complaints;
    - Plan of treatment;
    - Diagnostic tests;
    - Therapies and other prescribed regimens;
    - Follow-up visits, including encounter forms with notations concerning follow-up care, or visits; return times noted in weeks, months or as needed; and unresolved problems from previous visits are addressed in subsequent visits;
    - Referrals and results thereof; and
    - All other aspects of patient care, including ancillary services.

Medical records must be legible, meaning the record is legible to someone other than the writer. Any record judged illegible by one (1) physician reviewer must be evaluated by a second reviewer. The MCO must have a process to assess and improve the content, legibility, organization, and completeness of enrollee health records. Enrollee health records must be available and accessible to the MCO and to appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating enrollee grievances or complaints.

The MCO must ensure that there is appropriate and confidential, privacy protected, exchange of information among providers, such that a provider making a referral is able to transmit necessary information to the provider receiving the referral, a provider furnishing referral service is able to report appropriate information to the referring provider, and ensure all providers are able to request information from other treating providers as necessary to provide care. When an enrollee chooses a new PCP within the network, the enrollee's records are transferred to the new provider in a timely manner that ensures continuity of care. The MCO shall have a process for ensuring that enrollee information from out-of-network medical or behavioral health providers is shared with the enrollee's PCP.

The MCO must:

- Comply with the data exchange requirements at 42 CFR § 438.62 by developing and maintaining a process for the electronic exchange of information, including at a minimum, the data classes and elements included in the United States Core Data for

6.9.1 Establishment of Confidentiality Procedures

The MCO must establish confidentiality of data procedures:

1. To develop and promulgate policies in accordance with Federal and State law establishing who is authorized to receive such information;
2. To safeguard the privacy of any information that identifies a particular enrollee by ensuring that: information from the MCO or copies of records may be released only to authorized individuals; unauthorized individuals cannot gain access to or alter patient records; and original medical records must be released only in accordance with Federal or State law, court orders, or subpoenas;
3. To address the confidentiality and privacy for minors, subject to applicable Federal and State law; and
4. To abide by all Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and any information about an enrollee.

6.9.2 Maintaining Confidentiality of Medical Records

The MCO, its staff, contracted providers, and all contractors that provide cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation must maintain the confidentiality of medical record information and release the information only in the following manner:

1. All enrollee medical records are confidential and may not be released without the written consent of the covered persons or responsible party, except as specified below.
    a. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities that are providing services to enrollees under a Subcontract with the MCO. This provision also applies to specialty providers who are retained by the MCO to provide services that are infrequently used or are of an unusual nature. This also allows for transfer of information (written or verbal) to the Department staff and to the Department Subcontractors.
    b. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care, or to the MCO, its staff, contracted providers or its contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation.
    c. Written consent is required for the transmission of the medical record information of a former enrollee to any physician not connected with the MCO, except as set forth in (ii) above.
2. The extent of medical record information to be released in each instance will be based upon tests of medical necessity and a "need to know" basis on the part of the practitioner or a facility requesting the information. Medical records maintained by Subcontractors must meet the above requirements.

The MCO must survey a sample of its adult and child enrollees at least annually to determine enrollee satisfaction with the quality of MCO care and services. The MCO must use the latest available version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The survey tool must support reporting of the U.S. DHHS' Core Quality Measures for Adults and Children. The MCO must use content or methodology as directed by the Department. The MCO must submit to the Department a copy of any results submitted to National Committee for Quality Assurance (NCQA) within five (5) business days of submission to NCQA.

A comprehensive analysis of survey results must be reported to the Department annually, on or before August 15th. The analysis must include the methodology, overall response rate, and results for global ratings, composite scores, item-specific question summary rates, and any other measure specified by the Department. If the Department requires any additional measures to be reported from the survey results, the Department will notify the MCO at the time it approves the survey tool.

The MCO must use survey results to identify and investigate areas of enrollee dissatisfaction, outline action steps to follow-up on the survey findings, and share findings with providers. Concurrent with submission of the analysis of survey results on August 15th, the MCO must submit its action plan to the Department. The action plan must include implementation steps, a timeline for completion, and any other elements specified by the Department. Along with the action plan, the MCO must submit an evaluation describing the effectiveness of the previous' years interventions.

A separate satisfaction survey must be conducted for enrollees within the CSED waiver program. Satisfaction results less than eighty-six (86) percent require the submission of a Corrective Action Plan (CAP) by the MCO to improve performance for the following contract period. Failure to submit the MCO CAP in a timely manner shall result in a liquidated damage, as defined by Appendix F.

6.10.5 Encounter Reporting

The submission of complete and accurate encounter data is a condition of capitation payment to the MCO by BMS. The MCO is responsible for submitting complete and accurate encounter data for all services rendered that fall within the defined benefit package. The MCO must designate one (1) individual to work with BMS or its contractors on the submission of encounter data and resolution of any data issues, including issues with Transformed Medicaid Statistical Information System (T-MSIS) reporting to CMS.

6.10.5.1 Encounter Data Submission

The MCO must submit complete and accurate encounters in the form and manner described in 42 CFR 438.818 and in BMS guidance, including the Encounter Companion Guides for Professional, Institution, and Dental claims posted on the State MMIS website. Encounter data must follow the format and data elements as required by the HIPAA-compliant 837 transaction for medical and dental claims.

The MCO will submit encounter claims in their complete and original form, without altering, splitting, or removing data elements except as necessary to meet any MMIS standards for encounter submissions outlined in the Encounter Companion Guide. The MCO, through an authorized agent, must attest to the truthfulness, accuracy, and completeness of all encounter data each time data is submitted to BMS in accordance with 42CFR 438.606.

- A dictionary containing definitions for all codes contained on the encounter record that are not defined in the public domain. Such variables include but are not limited to, provider specialty, type of service, place of service, and internal procedure codes, and payment exception codes.

6.10.5.2 Changes to Encounter Data

The MCO will be required to comply with any changes that BMS intends to implement within sixty (60) calendar days of issuance, unless otherwise agreed to in writing by BMS within thirty (30) calendar days of issuance.

The MCO must provide BMS with a written notice at least ninety (90) calendar days prior to any system conversions and changes in coding. It must also provide a plan to work with the Department to ensure consistency of encounter data.

6.10.5.3 Data Accuracy and Completeness Monitoring Program

The MCO must have a data accuracy and completeness monitoring program in place that:

- Demonstrates that all claims and encounters submitted to the MCO by health care providers, including Subcontractors, are submitted accurately and timely as encounters to the Department;
- Evaluates health care provider and Subcontractor compliance with contractual reporting requirements; and
- Demonstrates that the MCO has the processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with all encounter reporting requirements outlined by BMS and CMS, including data elements required for HIPAA.

The MCO must submit an annual Data Accuracy and Completeness Plan to the Department for review and approval by October 1st for the current fiscal year. This Plan must include the three (3) elements listed above. Along with this submission, the MCO must submit documentation of its data file layout.

6.10.5.4 Errors in Submitted Encounter Data

The MCO must provide complete, accurate, and timely encounter data to the Department. If previously submitted encounter data is identified with a significant number of errors, the MCO will be required to re-submit corrected encounter data within thirty (30) calendar days of notification from the Department. The MCO must work with the Department to correct encounter data issues identified by CMS in any T-MSIS reporting within thirty (30) calendar days of notification. If system updates that may take longer than thirty (30) calendar days to implement are necessary to resolve the identified encounter data issues, the MCO will provide a detailed plan for corrections, including timeframes to resolve the issue(s), for Department approval within thirty (30) calendar days of notification. If the MCO is unable to resolve encounter data issues in a timely manner leading to T-MSIS data quality issues, the MCO may be subject to liquidated damages or other available remedies as outlined in Appendix F: Services Level Agreements and Liquidated Damages Matrix.

Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the MCO for immediate correction,

DUTY/INDEPENDENT NURSING UP TO 15 MIN authorizations effective on or after January 1, 2023. Each daily file will contain a full list of qualified authorizations cumulatively and be delivered via existing file transfer connections established with the State's assigned vendor. Only authorizations in the designated layout will be supplied to the state assigned vendor, and that vendor will format and deliver the MCO authorizations separately to the Electronic Visit Verification (EVV) Vendor. Upon receipt of the EVV Vendor response log files, the assigned vendor will distribute the response log files to the MCO.

6.10.10 Provider Network Reporting

The MCO must comply with reporting requirements required to assess compliance with network standards in a format and frequency to be specified by the Department.

6.10.11 Reporting of Required Reportable Diseases

Health care providers are required to report certain diseases by state law. This is to allow for both disease surveillance and appropriate case investigation/public follow-up. The MCO may be responsible for 1) further screening, diagnosis and treatment of identified cases enrolled in the MCO as necessary to protect the public's health, or 2) screening, diagnosis and treatment of case contacts who are enrolled in the MCO. Detailed infectious disease reporting requirements can be obtained from the Bureau for Public Health. The three primary types of diseases that must be reported are:

1. *Division of Surveillance and Disease Control, Sexually Transmitted Disease Program.* According to WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, sexually transmitted diseases (STDs) are required to be reported for disease surveillance purposes and for appropriate case investigation and follow-up. For contact notification, the MCO must refer case information to the Division of Surveillance and Disease Control. The Division has an established program for notifying partners of persons with infectious conditions. This includes follow-up of contacts to individuals with HIV and AIDS. Once notified, contacts who are enrollees of an MCO may be referred back to the MCO for appropriate screening and treatment, if necessary.
2. *Office of Prevention and Epidemiology Services (OEPS).* As per WV Code §16-3D-1 through 9 and 64 CSR 76, individuals with diseases caused by M. tuberculosis must be reported to the WV OEPS, TB Program for appropriate identification, screening, treatment, and treatment monitoring of their contacts.
3. *Division of Surveillance and Disease Control, Communicable Disease Program.* As per WV Legislative Rules Title 6-4, Series 7, cases of communicable disease noted as reportable in West Virginia must be reported to the local health departments in the appropriate time frame and method outlined in legislative rules. This both provides for disease surveillance and allows appropriate public health action to be undertaken—patient education and instruction to prevent further spread, contact identification and treatment, environmental investigation, outbreak identification and investigation, etc. (Note: Per legislative rule, reports of category IV diseases [including HIV and AIDS] are submitted directly to the state health department, not to local jurisdictions.)

The MCO must submit yearly statements to the Department, by October 1st, attesting that it has provided written notification to all participating providers on their responsibility to and procedures for reporting the three (3) primary types of diseases listed above to the State.

report within sixty (60) calendar days from the date of notification by the Department or its designee.

The MCO is required to use the most current Medicaid crosswalk provided by the Bureau for processing HCPCS claims. The crosswalk must be loaded into the vendor's claims processing system within thirty (30) calendar days of receipt for claims processing. If NDC on the submitted encounters do not align with the crosswalk, the claim line must be rejected by the MCO and returned to the provider for correction. The vendor must use and complete the specified file format for submitting HCPCS encounters for the Bureau for rebate processing. The MCO must use the data provided on this crosswalk as a reference, not the sole authority when making drug coverage determinations. The MCO must independently ensure that the drug coverage meets the definition of a covered-outpatient drug, which includes verifying that the manufacturer of the drug has an active Federal drug rebate contract via third-party vendors and/or publicly available Federal resources (including data.medicaid.gov). Instances where an inaccuracy on the crosswalk is found to result in failure of a claim to be accepted by PRIMS will not be considered a rejection. Any potential inaccuracy noted by the MCO on this crosswalk must be reported to the Department immediately.

Each encounter containing a drug filled from 340B stock must include a 340B indicator, supplied by the provider at the time of billing, verifying whether or not a 340B drug was dispensed/administered to the Medicaid enrollee. The MCO must report this information using a standardized file layout supplied by the Department. The MCO must validate their 340B drug costs claim data by confirming that drug costs for 340B drug encounters do not exceed non-340B costs for the same drug and provide quarterly attestation that the verification has been completed. The MCO must use formats provided in Appendix E for providing attestation.

Drug rebate encounters are included in the overall ninety-five (95%) encounters acceptance standard outlined in Article III, Section 6.4 and subject to the relevant liquidated damages outlined in Appendix F.

6.10.15 Provider-Preventable Conditions

The MCO must comply with any reporting requirements mandated by CMS to document the occurrences of PPCs in the Medicaid program. The format will be specified by the Department, with reporting occurring on an annual basis.

6.10.16 Mental Health Parity Report

The MCO must provide the Department with quarterly reports of mental health parity data in formats to be specified by the Department. The quarterly reports must include data for the following areas:

- Outpatient prior authorization counts by benefit type;
- Inpatient prior authorization counts by benefit type;
- Enrollment/credentialing counts by provider type;
- Enrollee complaints by NCQA category

In addition, the MCO shall provide a quarterly report of the average wait time to access mental health services from the date of referral by a primary care or other referring provider, to the time the youth is seen by a mental health care professional.

1. Annual measurement of performance in specified areas (e.g., immunization rates) and achievement of performance targets;
2. Multi-year PIPs addressing clinical and non-clinical areas;
3. An approach for addressing systematic problems and critical incidents;
4. The development and usage of a sufficient health information system; and
5. Proper administration of QAPI activities.

The MCO must submit performance measurement data to the Department or its designated contractor annually, on or before June 15th, and as otherwise required by the Department. The QAPI must include mechanisms to detect both underutilization and overutilization of services, and to assess the quality and appropriateness of care provided to enrollees with special health care needs. The MCO must report on the status and results of projects annually. Projects must be completed within a reasonable timeframe. The basic elements of the MCO's QAPI must comply with the requirements set forth in this contract.

The MCO must also cooperate with the Department initiatives aimed at assessing and improving program performance. These initiatives can include regular reporting to the State and an annual external quality review consisting of an on-site systems performance review of quality outcomes, timeliness of, and access to services covered under this contract. The MCO must make every effort to comply with external quality reviews that will be implemented by an organization contracted by the Department. This may include participating in the design of the external review, collecting medical records and other data, and/or making data available to the EQRO.

7.1 Required Levels of Performance

The MCO must meet certain required standards of performance when providing health care and related services to Medicaid managed care enrollees. The MCO must meet all goals for performance improvement on specific measures that may be established by the Department. These minimum performance standards will be established by examining historical performance standards as well as benchmarks (best practices) of other health plans and delivery systems. Performance standards for each quality review period will be provided to the MCO by the Department.

7.2 Performance Improvement Projects (PIPs)

In accordance with 42 CFR §438.330, the MCO must develop and maintain written descriptions of its performance improvement program, including the identification of individual(s) responsible for the program. The MCO must conduct PIPs that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. PIPs must measure performance using objective quality indicators, implement system interventions to achieve quality improvements, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements.

An individual project involves selecting an aspect of clinical care or non-clinical services to be studied; specifying quality indicators to measure performance; collecting baseline data; identifying and implementing appropriate system interventions to improve performance; and repeating data collections to assess the continuing effect of interventions.

measurement data to the Department using Department-determined standard measures, including performance measures that may be developed by CMS.

If sampling is used, the MCO's sampling methodology must ensure that the data collected validly reflect the performance of all providers whose activities are the subject of the indicator; and the care given to the entire population (including special populations with complex care needs) to which the indicator is relevant.

The MCO must also demonstrate that its interventions result in meaningful improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each PIP undertaken by the MCO. The MCO must show that the PIP is working effectively to reach defined quality goals by showing that an improvement occurred; is likely to result in a better outcome for the enrolled population; is attributable to the strength, duration and quality of the MCO's action(s), and not to "confounders" such as chance; and impacts high-volume, high-risk, and/or high-cost conditions or services.

PIPs are deemed successful and may terminate once sustained improvement is achieved. Sustained improvement is acknowledged through the documentation and maintenance of improved indicator performance. After improvement is achieved, it must be maintained for at least one (1) year. The MCO must submit a CAP that addresses deficiencies identified in any measurement data.

Each PIP must demonstrate effort to achieve meaningful improvement and be completed in a reasonable time period, as determined by the Department. Project reports must be reported by July 15th in order to facilitate the use of resulting data in producing annual information on quality of care. The MCO is required to submit a PIPs progress report one-hundred twenty (120) calendar days after the end of each quarter. The report must follow the Department -approved format.

7.3 Systemic Problems

The MCO must correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms (such as notice from the Department). The MCO must have written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written remedial/corrective action procedures must include:

1. Specification of the types of problems requiring remedial/corrective action;
2. Specification of the person(s) or body responsible for making the final determinations regarding quality problems;
3. Specific actions to be taken;
4. Provision of feedback to appropriate health professionals, providers, and staff;
5. The schedule and accountability for implementing corrective actions;
6. The approach to modify the corrective action if improvements do not occur; and
7. Procedures for terminating the affiliation with the physician, or other health professional or provider.

7.5 Administration of the QAPI Program

The MCO's QAPI program must be administered through clear and appropriate administrative arrangements consistent with the Medicaid requirements of 42 CFR §438.240. The MCO must ensure that sufficient resources and staff with necessary education, experience, or training are available to implement the QAPI.

7.5.1 Written QAPI Program Plan Description

The MCO must have a written plan describing its QAPI program, including how the MCO will accomplish the activities required by this section. The QAPI program plan at a minimum must specify clinical or health services delivery areas to be studied that represent the population served by the MCO in terms of age groups, disease categories, and special risk status. The QAPI program plan must describe the MCO's PIPs and any other quality activities that will be undertaken over a prescribed time period. The QAPI program plan must clearly identify the individuals responsible for the activities. Any additional MCO quality activities must use quality indicators that are measurable, objective, and based on current knowledge and clinical experience. The QAPI program plan must define a methodology and frequency of data collection that assures appropriate and sufficient monitoring to detect need for changes in the QAPI program plan.

7.5.2 Policymaking Body

A policymaking body, defined as the governing body of the MCO or a committee of senior executives that exercises general oversight over the MCO's management, policies, and personnel, must oversee and be accountable for the QAPI program. The policymaking body must approve any changes in the QAPI program description and approve the annual work plan. The policymaking body must receive and review periodic reports on QAPI activities, as well as the annual evaluation, and take action on any resulting recommendations.

7.5.3 QAPI Committee

A designated senior official must be responsible for the functioning of the QAPI program. If the responsible official is not the Chief Medical Officer, the MCO must show, through the QAPI program description or other documentation, that the Chief Medical Officer has substantial involvement in QAPI activities. The MCO's QAPI committee must meet at least quarterly to oversee QAPI activities and review of the process followed in the provision of health services. Providers must be kept informed about the written QAPI program. Contemporaneous records must document the committee's activities, findings, recommendations, and actions. The QAPI committee will report to the QAPI Policy committee on a scheduled basis on activities, findings, recommendations, and actions. Membership on the QAPI committee must include MCO employed or affiliated providers representative of the composition of the MCO providers. If affiliated providers are not represented on the MCO's QAPI committee or other core coordinating structure, there must be a clinical subcommittee or other advisory group to assure that clinicians actively participate in key activities.

7.5.4 Other QAPI Participants

Employed or affiliated providers and consumers must actively participate in the QAPI program. All contracts with providers must require participation in QAPI activities, including provision of access to medical records, and cooperation with data collection activities. Consumer involvement must be sought from the outset of the MCO's QAPI program planning.

and to other external standards and/or benchmarks. The Department will allow the MCO opportunity to review its data for accuracy and/or validity prior to publication.

7.8 Quality Withhold Program

Beginning at such time as required by BMS, the State may establish a quality withhold program that establishes quality metrics that align with the Department's goals as outlined under WV Code Chapter 49; requirements of the Department of Justice; and other HEDIS and CAHPS measures as selected by the Department.

On an annual basis, the Department or its designee will evaluate whether the MCO has demonstrated that it has fully met the performance measures for which the MCO is at risk. The Department or its designee will determine the extent to which the MCO has the met performance measures by assessing each MCO's report relative to performance targets for the corresponding baseline year. If the MCO does meet some or all of the performance measures, the Department will issue a portion or entire sum of the withheld capitation as a lump sum payment to be paid no later than November of each corresponding year.

8. FINANCIAL REQUIREMENTS & PAYMENT PROVISIONS

8.1 Solvency Requirements

The MCO must make provisions against the risk of insolvency and assure that neither enrollees nor the Department are held liable for debts in the event of the MCO's insolvency or the insolvency of any Subcontractors. The MCO must demonstrate adequate initial capital reserves and ongoing reserve contributions in accordance with the Insurance Commissioner's requirements. The MCO must provide financial data to the Department in accordance with Department required formats and timing.

The MCO must maintain a fiscally sound operation as demonstrated by the following:

1. Maintaining adequate liquidity to meet all obligations as they become due for services performed under the provider agreement.
2. Maintaining a positive net worth in every annual reporting period as evidenced by total assets being greater than total liabilities based on the MCO's annual audited financial statement. If the MCO fails to maintain a positive net worth, the MCO must submit a financial plan for Department approval outlining how the MCO will achieve a positive net worth by the next annual reporting period.
3. Maintaining a net operating surplus in every annual reporting period based on the annual audited financial statement. If the MCO fails to earn a net operating surplus, the MCO must submit a financial plan for Department approval outlining how the MCO will achieve a net operating surplus within available financial resources by the end of the next annual reporting period.

If insolvency insurance protection is carried as a rider to an existing reinsurance policy, the conditions of the coverage must not exclude the MCO's Medicaid line of business.

The MCO must notify the Department in writing within sixty (60) calendar days if any changes are made to the MCO's insolvency protection arrangement.

8.2.2 Medical Loss Ratio (MLR)

8.2.2.1 MLR Calculations

The MCO is required to calculate and report MLR for each fiscal reporting year, consistent with MLR standards as outlined in 42 CFR §438.8(a). The MCO is required to maintain a MLR of at least eighty-five percent (85%) during the fiscal year reporting period for the combined Medicaid population. The MLR will be calculated by the MCO using the methodology as described in Appendix G of this Contract.

The MCO must submit an annual MLR report that documents the CSED and non-CSED populations separately. The combined Medicaid MLR will be used for rebating purposes in addition to separate detail broken out for the population in accordance with Appendix G of this Contract that includes at least the following:

1. Total incurred claims
2. Expenditures on quality improvement activities
3. Expenditures related to activities necessary to comply with program integrity requirements under this Contract
4. Non-claims costs
5. Premium revenue
6. Taxes
7. Licensing fees
8. Regulatory fees
9. Methodology(ies) used for allocation of expenses
10. Any credibility adjustment applied
11. MLR calculated by the MCO
12. If applicable, any remittance owed to the Department
13. A comparison of the information reported with the MCO's annual audited financial report
14. Description of the aggregation method used to calculate total incurred claims
15. Total enrollee months

An MLR percentage for each respective population of less than eighty-five percent (85%) must be one hundred percent (100%) reimbursable to the State.

For purposes of this contract, the State shall reimburse the MCO eighty percent (80%) of costs incurred that exceed ninety-five percent (95%) MLR for those services meeting the reporting definition.

If an MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

MCOs, PIHPs, or PAHPs will aggregate data for all Medicaid eligibility groups covered under the contract with the State.

or private sources, including Medicare. This responsibility includes accident and trauma cases that occur while a Medicaid beneficiary is enrolled in the MCO. If there is no established liable third party at the time of service, but later a third party is identified as liable for the claim, the MCO must seek to recover the payment. This may occur when the Medicaid beneficiary requires medical services in casualty/tort, medical malpractice, Worker's Compensation, or other cases where the third party's liability is not determined before medical care is provided. It may also occur when the MCO learns of the existence of health insurance coverage after medical care is provided. The MCO or its Subcontractor must first seek recovery from the liable third party. If that is not feasible (for example, with Medicare), it may be necessary to recoup the payment from the provider and ask the provider to rebill correctly.

The MCO must review service information to determine that all third party payment sources are identified and payment is pursued. The MCO will retain all funds collected as part of this activity during the initial three hundred and sixty-five (365) day recovery window, or during a BMS approved extension of the MCO recovery window.

8.3.4 TPL Reporting

If the MCO determines that it will not pursue a Third Party Liability (TPL) case that is known to the MCO, the MCO must notify the Department on the fifteenth (15^{th}) of each month by submitting an electronic file, in a format to be specified by the Department, listing these identified TPL cases. For these cases, the Department or its contractor will have the sole and exclusive right to pursue, collect, and retain recoveries of these third party payments.

The MCO must also report TPL information in a file format to be specified by the Department, including status updates on any cases identified for pursuit on a monthly basis. The MCO must contact the Department if it becomes aware that an enrollee has become eligible for Medicare while on Medicaid. It must also notify the Department as it becomes aware of other insurance coverage.

Confidentiality of the information will be maintained as required by federal regulations, 42 CFR §431 Subpart F and 42 CFR Part 2.

8.3.5 Pay and Chase

Even when TPL has been identified, the MCO must pay the claim and then seek payment from TPL in the following scenarios or for the following services:

1. **Medical Support Enforcement** – if the claim is for a service provided to an individual on whose behalf child support enforcement is being carried out if: 1) the third-party coverage is through an absent parent; and 2) the provider certifies that, if the provider has billed a third party, the provider has waited ninety (90) calendar days from the date of service without receiving payment before billing Medicaid. This requirement is intended to protect the custodial parent and the dependent children from having to pursue the non-custodial parent, his/her employer, or insurer for TPL.
2. **Labor & Delivery and Postpartum Care** – for claims for labor and delivery and postpartum care (but not for inpatient hospital costs associated with labor and delivery).
3. **Pediatric Preventive Services** – for claims for pediatric preventative services, (including immunizations and EPSDT screenings and preventive services) unless BMS has made a

8.4.2 Loss of Medicaid Eligibility

The MCO is not responsible for the inpatient facility charges for an enrollee who is no longer eligible for Medicaid coverage as of the first (1st) of the month following the loss of Medicaid coverage.

8.4.3 Excluded Providers

In accordance with 42 CFR §1001.1901(c)(5), payment under Medicaid is not available for excluded providers except for emergency medical services or items. The MCO is prohibited from paying for an item or service:

- Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act, as outlined in Article II, Section 8.7.3 of this contract.
- Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person), as outlined in Article II, Section 8.7.3 of this contract.
- Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments, as outlined in Article III, Section 9.2 of this contract.

To be payable, a claim for such emergency items or services must be accompanied by a sworn statement of the person furnishing the items or services specifying the nature of the emergency and why the items or services could not have been furnished by an individual or entity eligible to furnish or order such items or services. No claim for emergency items or services will be payable if such items or services were provided by an excluded provider who, through an employment, contractual or any other arrangement, routinely provides emergency health care items or services.

8.4.4 Maternity Kick Payments

The Department may provide special payments for certain maternity services, as outlined in Contract Appendix B, Capitation Rates.

8.4.5 Payments to Durable Medical Equipment (DME) Providers

The MCO must reimburse at least one hundred percent (100%) of the current FFS Medicaid fee schedule to in-network DME providers, unless such provider agreed to an alternative payment schedule. The Department will notify the MCO of any changes in the FFS Medicaid schedule as soon as administratively possible. The MCO must adjust the reimbursement schedule to in-network provider within thirty (30) calendar days of the Department's notification of any changes in the FFS Medicaid schedule.

The MCO must submit to the Department a bi-monthly report identifying enrollees ages twenty-one (21) to sixty-four (64) with an IMD stay of greater than fifteen (15) days during the calendar month. This report must be provided to BMS on the 16th and 31st of each month.

The MCO must engage with the IMD facility to initiate discharge planning to facilitate the enrollee's successful return to the community. The MCO must make every reasonable attempt to identify appropriate outpatient services for the enrollee.

This IMD provision is not applicable to inpatient psychiatric hospital services for individuals under age twenty-one (21) as defined in 42 CFR §440.160.

8.5 Enrollee Liability

The MCO cannot hold an enrollee liable for the following:

1. The debts of the MCO if it should become insolvent;
2. Payment for services provided by the MCO if the MCO has not received payment from the Department for the services, or if the provider, under Contract or other arrangement with the MCO, fails to receive payment from the Department or the MCO; or
3. The payments to providers that furnish covered services under a Contract or other arrangement with the MCO that are in excess of the amount that normally would be paid by the enrollee if the service had been received directly from the MCO.

A participating provider may not balance bill enrollees for covered services. More specifically, a participating provider cannot bill for the difference between the provider's charge and the allowed amount. Providers must be in compliance with Section 1902(n)(3)(B) of the Social Security Act, and Section 1417 of the Balanced Budget Act of 1997.

8.6 Managed Care Premium Tax

Pursuant to 42 CFR §438.5(e), the premium tax will be part of the non-benefit component of the capitation rates, and, as such, the cost of the tax on the MCO will be inclusive in the PMPM capitation rates paid to the MCO in accordance with the tax levied under West Virginia Code §11-27-10a:

BMS will perform the annual end year reconciliation (based on data submitted from July 1 – June 30) of the premium tax amounts at the MCO level as compared to the premium tax component included in the PMPM. Once each MCO's semi-annual premium tax amount is known, the State will reconcile that to the amount paid through the capitation payments. If the amount paid is less than the premium tax amount, an increase will be made to future capitation payments. If the amount paid is greater than the premium tax amount, a decrease will be made to future capitation amounts.

9. FRAUD, WASTE, AND ABUSE REQUIREMENTS

9.1 Fraud, Waste, and Abuse Guidelines

9.1.1 General Requirements

Program Integrity requirements under the contract are outlined in 42 CFR §438.608 and are incorporated herein by reference. The MCO must have administrative and management

Department or MFCU records requests will be sent to the designated MCO contact person(s) in writing via email, fax, or regular mail and will provide the specifics of the information being requested. The MCO must respond to the appropriate Department or MFCU staff enrollee within fourteen (14) calendar days or within the timeframe designated in the request. If the MCO is unable to provide all of the requested information within the designated timeframe, an extension may be granted and must be requested in writing by the MCO no less than two (2) business days prior to the due date. The data, records, or information must be provided in the order and format requested.

9.1.3 Internal Compliance Plan

The MCO or its subcontractor, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the state and the MCO, is required to implement and maintain a compliance program. The MCO and its subcontractors must have in place internal controls, policies, and procedures to prevent and detect FWA and must have a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones.

9.1.3.1 Required Elements of the Internal Compliance Plan

The MCO's Medicaid compliance plan must include the following elements:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements;
2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to an Executive Compliance Officer at the corporate level of the organization and indirectly to the CEO/COO;
3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organizations compliance program and its compliance with the requirements under the contract;
4. A system for training and education of the Compliance Officer and the organization's employees, including senior management, on state and federal standards and requirements under the contract;
5. Effective lines of communication between the Compliance Officer and the organization's employees;
6. Enforcement of standards through well-publicized disciplinary guidelines; and
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination with law enforcement in instances of criminal acts) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

a. Overutilization of services, including non-emergent emergency care; or

b. Card-sharing.

The MCO must submit a report summarizing the MCO's activities and results of these monitoring analyses for the current state fiscal year to the Department by June 15th of each year.

The MCO must educate providers for which findings of any FWA case indicate errors in billing as part of the overpayment recovery process. Education may be provided through means such as information provided as part of an overpayment demand letter, corrective action, or a separate educational package. Education must be individualized to the servicing provider and particular to the issued identified as causing the overpayment.

The MCO must have procedures in place for notification to the Department within five (5) business days of the MCO becoming aware of an enrollee's death, change of address, or other changes in an enrollee's circumstances that may affect eligibility.

The MCO must have a procedure in place for prompt notification to the Department when the MCO becomes aware of a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO.

9.1.4 Fraud, Waste, and Abuse Reports

The MCO must submit a report to the Department within fifteen (15) calendar days of the end of each month regarding program integrity activities and suspected FWA identified during the prior month. The report must conform to the FWA Report template provided by the Department and must include complete information on the following program integrity activities:

1. All program integrity activities initiated by the MCO or its contractors, and related outcomes;
2. Referrals made to the Department /MFCU;
3. Clear documentation in closure of a review, for the following:
    a. All overpayments identified, including those unrelated to program integrity (i.e., administrative overpayments), per 42 CFR §438.608;
    b. All overpayments recovered, including those unrelated to program integrity (i.e., administrative overpayments), per 42 CFR §438.608;
    c. All overpayments for which a reduced amount was collected;
    d. The method of collection;
    e. If an overpayment was not collected, supporting information as to the reason it was not collected; and
    f. If the review was closed with no further action, a statement as to why no further action was taken.

The MCO must submit to the Department by the fifteenth (15th) day of each month the Suspension and Adverse Enrollment Action report for all in-network suspensions, terminations for cause, and provider credentialing denials and non-renewals for cause during the prior

9.2.1 Provider Payment Suspension

The MCO is required to cooperate with the Department when payment suspensions are imposed on the Medicaid provider by the Department. When the Department sends notice that payments to a provider have been suspended, the MCO must also suspend payments to the provider within one (1) business day if such provider is in the MCO network and receives payments. When such notice is received from the Department by the MCO, the MCO must respond to the notice within three (3) business days and inform the Department of whether the MCO has implemented the suspension.

The MCO must also report all of the following information to the Department monthly: name of the suspended MCO provider, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, amount of payments held, and, if applicable, the good cause rationale for not suspending payment (for example, the provider is not enrolled in the MCO's network) or imposing a partial payment suspension. The MCO must include in its monthly report those providers that the MCO was notified of by the Department. Reports must also include the amount withheld from providers on a cumulative basis. This information must be reported on the Suspension and Adverse Enrollment Action Report template created by the Department. If the MCO does not suspend payments to the provider, the Department may impose contractual remedies.

The Department is responsible for evaluating allegations of fraud and imposing payment suspensions, when appropriate, for those MCO providers who are a part of the State FFS network. The MCO is responsible for initiating payment suspensions based on the credible allegation of fraud for its in-network providers who are not a part of the State FFS network. For payment suspensions initiated by the MCO, the MCO must comply with all requirements of 42 CFR §455.23. The MCO must report the following information to the Department within one (1) business day after suspension: the nature of the suspected fraud, basis for the suspension, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of any appeals, the amount of payments held, and, if applicable, the good cause rationale for imposing a partial payment suspension.

9.3 Treatment of Overpayments

The retention of overpayments is dependent upon the circumstances under which such overpayments are identified and investigated. If the MCO does not identify and take action to recover provider overpayments in a timely manner, the Department reserves the right to identify, recover, and retain said overpayments. The Department will afford the MCO a reasonable grace period, as determined by the Department, to identify and recover overpayments from MCO providers before the Department will seek to recover and retain said overpayments.

The Department and the MCO will participate cooperatively in deconfliction procedures to prevent duplication of program integrity activities. The monthly FWA report submitted by the MCO pursuant to Article III, Section 9.1 of the Contract and the Department's Notice of Program Integrity Activities will be utilized as deconfliction tools. Deconfliction will occur regardless of the grace period determined by the Department.

9.3.1 Department's Right to Collect from MCO

The Department shall have the right to recover provider overpayments, including those overpayments due to WFA, from the MCO if:

1. The MCO was not required to abstain from collections from the provider, due to a MFCU or other law enforcement investigation;
2. The Department has not duplicated this recovery, consistent with this section;
3. The MCO followed proper procedures regarding fraud and/or abuse referrals to the Department;
4. The MCO properly and timely disclosed the required information on its monthly FWA report;
5. The encounter data is properly adjusted to reflect the recovery; and
6. Such recovery is not prohibited by federal or state law.

If the MCO fails to adhere to the prohibitions and requirements of this section, the MCO may be subject to forfeiture of the funds to the Department and the imposition of liquidated damages as described in Appendix F.

If an overpayment has been referred by the MCO to the Department, due to suspected fraud or abuse, and is subsequently returned to the MCO, the MCO may collect and retain these overpayments directly from the provider, consistent with this section. However, if the MCO has not taken action to collect the overpayment within ninety (90) calendar days of reported identification of the overpayment to the Department, the Department may collect and retain the monies.

If the Department identifies a suspected overpayment, also referred to as a "lead," and refers that lead to the MCO for further investigation and recovery, the MCO will retain one hundred percent (100%) of its recoveries, pursuant to the requirements and prohibitions outlined in (a) through (f) above. If the Department has partially completed an audit or investigation, and, in its sole discretion, the Department refers that information to the MCO for further investigation and recovery, the Department and MCO may negotiate a percentage division of any recoveries to be split by the Department and the MCO, on a case-by-case basis. The Department reserves the right to resume the audit or investigation if no agreement as to percentage division of any recovery can be agreed upon. If the Department, or an entity contracting with the Department, performs the entire investigation leading to identification of the overpayment, thereby giving it the right to keep one hundred percent (100%) of the overpayment, the Department, in its sole discretion, may opt to divide the recoveries with the MCO in an amount determined by the Department.

Pursuant to 42 CFR §438.608(d)(1), this provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

9.3.4 MCO's Opportunity to Participate in Fraud Recoveries

The MCO must submit fraud and abuse referrals to the Department using the prescribed form. Referral information submitted to the Department by an MCO will be distributed to all potentially impacted MCOs, along with an RFI. Upon receipt of the referral information and RFI, the MCO must respond by the due date included in the RFI. Failure to respond timely, completely, and accurately may result in the MCO not participating in any related fraud recoveries, and may also result in liquidated damages as described in Appendix F.

10.2 MHP Adult Dental Services Administration and Covered Services

The MCO must provide enrollees twenty-one (21) years of age and older with diagnostics, preventive, and restorative dental services, excluding cosmetic services. These services have a $2,000 per two (2) calendar year maximum benefit as specified in WV Policy Chapter 505 Oral Health Services. The MCO must place appropriate prior authorization limits on all covered adult dental services a service on the basis of such criteria as medical necessity or for utilization control, consistent with the terms of this Contract and clinical guidelines. Covered adult dental services will require authorization prior to services being rendered. The MCO must develop and submit policies and procedures for dental services to the Department for prior approval.

The MCO may employ the services of a Dental Contractor serving as a dental benefit manager or utilization review agent if such a manager or agent covers the adult dental benefit equivalent to the requirements described in Appendix A and in accordance with this Contract. If the MCO elects to employ the services of a Dental Contractor or utilization review agent, the MCO is required to comply with all Subcontractor requirements outlined in this Contract.

The MCO covered services must be provided by a licensed dentist or dental specialist in an office, clinic, hospital, ambulatory setting, or elsewhere when dictated by the need for diagnostic, preventive, therapeutic, or palliative care, or for the treatment of a particular injury as specified in Appendix A of this Contract.

Enrollees are responsible for payment of service costs exceeding the $2,000 per two (2) calendar year limit as specified in WV Policy Chapter 505 Oral Health Services. Before providing dental services to an enrollee, providers must first furnish the enrollee with a document to be signed in advance of the service, stating that the enrollee understands that dental services exceeding the $2,000 limit will be the responsibility of the enrollee. Services classified as cosmetic in nature are not covered for adults over the age of twenty-one (21).

Effective July 1, 2024, the MCO will reset each enrollee's benefit utilization to zero dollars ($0) and establish tracking mechanisms to identify the amount of payment for service costs each enrollee incurs. Until such time that a process is established for the MCO to receive dental service utilization data from the Department or its vendors, the MCOs will share data for enrollees who change enrollment to another MCO to assist with tracking efforts and to monitor utilization trends.

The MCO will include information in the Adult Dental Report identifying enrollees who have reached their benefit limit of $2,000, and will conduct specific reviews and tracking of those enrollees to confirm they are remaining on plan. The MCO will complete outreach to these enrollees to provide additional education about the benefit, that any dental services received must be paid out of pocket, and to provide the date on which they will be eligible for continued dental benefits (i.e., the date the new two-year budget period begins) if still eligible for Medicaid.

The MCO will conduct enrollee education campaigns about the changes in the dental benefit effective July 1, 2024 via methods such as updates to the enrollee handbook, community events, and enrollee mailings. The MCO will also conduct provider education and develop bulletins to post on its provider portal to educate and remind providers to contact the MCO's third party administrator (TPA) to obtain information on current utilization of the benefit over the next two (2) years.

are furnished.[17] The benefit must be provided in accordance with 42 CFR §438 Subpart K, Parity in Mental Health and SUD Benefits. The MCO must develop and maintain an ongoing Mental Health Parity Compliance Plan to be submitted to the Department annually by June 30th. The MCO is not subject to implementation of parity requirement associated with quantitative treatment limits of prescription drugs, as this benefit is administered under FFS.

The MCO may place appropriate limits on a service on the basis of such criteria as medical necessity or utilization control, consistent with the terms of this Contract and clinical guidelines. The MCO may not impose an aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental health or SUD services.

The MCO must not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of any type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees, to maintain compliance with the Bureau's Mental Health Parity Plan.

If an MCO enrollee is provided mental health or SUD benefits in any classification of benefits (inpatient, outpatient, emergency care or prescription drugs), mental health or SUD benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.

The MCO may not impose quantitative or non-quantitative treatment limits (QTL/NQTLs) for mental health or SUD benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the QTL/NQTL to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

The MCO may cover, in addition to services covered under the Medicaid State Plan, any service necessary for compliance with the requirements for parity in mental health and SUD benefits in 42 CFR §457.496.

The MCO must have an innovation plan to address behavioral health adolescents who may be at a higher risk for higher levels of care, which include, but are not limited to, a comprehensive adolescent BH risk assessment, preventative strategies, and technology-enabled solutions.

The MCO may employ the services of a Subcontractor serving as a behavioral health benefit administrator or utilization review agent if such administrator or agent covers the behavioral health benefit equivalent to the requirements described in Appendix A and in accordance with this contract. If the MCO elects to employ the services of a benefit manager or utilization review agent, the MCO is required to comply with all Subcontractor requirements outlined in this contract.

A mental health screening shall be completed for any child not already known to be receiving mental health services when the child enters Department Youth Services, the child welfare system, or the juvenile justice system; or when the child or family requests mental health

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[17] 42 CFR § 438.210

3. The MCO is not responsible for claims incurred within the inpatient behavioral health or residential treatment setting if an enrollee entered the treatment setting as an FFS enrollee;
4. The MCO is not responsible for claims incurred within the inpatient behavioral health treatment settings if an enrollee entered the treatment setting as an enrollee of another MCO;
5. The MCO is not responsible for any claims incurred during residential treatment facility stay for individuals twenty-one (21) years of age or older;
6. Notwithstanding any of the provisions of Article III, Section 11.5, the MCO is responsible for any claims incurred during involuntary inpatient facility stay.

11.6 Children's Inpatient Care for Behavioral Health

1. The MCO is responsible for all claims incurred within the inpatient behavioral health or psychiatric treatment settings covered by managed care;
2. The MCO is not responsible for claims incurred within the inpatient behavioral health or psychiatric treatment setting if an enrollee entered the treatment setting as an FFS enrollee; and
3. The MCO is not responsible for claims incurred within the inpatient behavioral health or psychiatric treatment settings if an enrollee entered the treatment setting as an enrollee of another MCO.

11.7 Court Ordered Services

If any court issues an order for Medicaid covered services listed as an MCO covered benefit under Appendix A and provided by a West Virginia Medicaid enrolled provider, the MCO must comply with the court order and pay for the services. To encourage the use of the most appropriate treatment options for the child, the MCO must establish and provide to BMS and the Bureau for Social Services (BSS) an approach of informing the BSS of alternative services that would best meet the needs of the child.

11.8 Behavioral Health Provider Network

The MCO must comply with this section notwithstanding Article III, Section 3 of this Contract.

The MCO must reimburse at least one hundred percent (100%) of the current FFS Medicaid fee schedule to in-network behavioral health provider, unless such provider agreed to an alternative payment schedule. The Department will notify the MCO of any changes in the FFS Medicaid schedule as soon as administratively possible. The MCO must adjust the reimbursement schedule to in-network behavioral provider within thirty (30) calendar days of the Department's notification of any changes in the FFS Medicaid schedule.

11.9 Behavioral Health Service Authorization

In addition to the service authorization requirements outlined in Article III, Section 6.4, the MCO must utilize the Department's standard behavioral service authorization format or other authorization format approved by the contracted provider.

Partial hospitalization programs must be approved by the Department before the MCO may offer the services to its enrollees by that provider.

4. Outpatient Services (1.0 ASAM® Level of Care);
5. Intensive Outpatient Services (2.1 ASAM® Level of Care);
6. Partial Hospitalization Services (2.5 ASAM® Level of Care);
7. Medically Monitored Intensive Inpatient Services (3.7 ASAM® Level of Care);
8. Medically Managed Intensive Inpatient Services (4.0 ASAM® Level of Care);
9. Ambulatory Withdrawal Management Services (1-WM & 2-WM ASAM® Level of Care);
10. Medically Monitored Inpatient Withdrawal Management Services (3.7-WM ASAM® Level of Care); and
11. Non-Methadone Medication Assisted Treatment (MAT).

11.10.3.2 SUD 1115 Demonstration Waiver Services

SUD 1115 demonstration waiver services include:

1. Peer Recovery Support Services (1.0 ASAM® Level of Care);
2. Clinically Managed Low Intensity Residential Services (3.1 ASAM® Level of Care);
3. Clinically Managed Population-Specific High Intensity Residential Services (3.3 ASAM® Level of Care);
4. Clinically Managed High Intensity Residential Services (3.5 ASAM® Level of Care); and
5. Clinically Managed Residential Withdrawal Management Services (3.2-WM ASAM® Level of Care).

BMS has requested approval from CMS to implement the below additional services under the SUD 11115 demonstration waiver. At such time that BMS determines such services will be implemented, the MCO will provide for these services for enrollees and seek to contract with additional provider types as necessary. Upon request, the MCO must collaborate with BMS in planning for and implementation of these services.

1. Expanded Length of Stay in IMDs;
2. Expansion of Residential Treatment at 3.7 ASAM® Level of Care for Medically Complex Individuals;
3. Group Residential Treatment Services;
4. Recovery Housing;
5. Supported Housing Services;
6. Supported Employment Services;
7. HIV and HCV Service Integration, Education and Community Outreach;
8. Continuity of Care for Justice-Involved Individuals with SUD;
9. Involuntary Secure Withdrawal Management and Stabilization (SWMS);
10. Quick Response Teams (QRTs); and

1. Residential treatment services must be provided in a BMS-certified facility that has been enrolled as a Medicaid provider and has been assessed by the Department as delivering care consistent with ASAM® Levels 3.1. 3.3, 3.5, and/or 3.7.
2. The BMS-certified facility must be credentialed and enrolled by an MCO as a network provider. Each residential treatment provider will be certified as meeting the provider and service specifications described in the West Virginia Medicaid Provider Manual, Chapter 504 consistent with the ASAM® criteria for the requisite level or sublevel of care prior to participating in the West Virginia Medicaid program under the SUD 1115 demonstration waiver. The MCO will provide credentialing for ASAM® Levels 3.1, 3.3, 3.5 and/or 3.7 contingent on the providers receiving certification from the state.
3. Residential treatment services can be provided in settings of any size.
4. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Covered Residential Treatment services include:

1. Clinically-directed therapeutic treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies;
2. Addiction pharmacotherapy and drug screening;
3. Motivational enhancement and engagement strategies;
4. Counseling and clinical monitoring;
5. Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from or occurring with an individual's use of alcohol and other drugs;
6. Regular monitoring of the individual's medication adherence;
7. Recovery support services;
8. Counseling services involving the beneficiary's family and significant others to advance the beneficiary's treatment goals, when (l) the counseling with the family member and significant others is for the direct benefit of the beneficiary, (2) the counseling is not aimed at addressing treatment needs of the beneficiary's family or significant others, and (3) the beneficiary is present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals; and
9. Education on benefits of MAT and referral to treatment as necessary.

11.10.4 Use of ASAM® Criteria

The MCO and all SUD providers are required to incorporate the national patient assessment and placement guidelines as established in the ASAM® Criteria, into current assessment and LOC determination processes. The multidimensional assessment framework will be implemented as a standard component of the bio-psychosocial assessment and LOC determination process.

11.10.5 SUD Provider Certification, Credentialing, and Network

The Department's ASO contractor for the SUD waiver will complete the SUD provider certification process and provide a report to the Department. Final certification letters will be

11.11.1 CSED HCBS Waiver Eligibility

To be eligible for the waiver children must be at least three (3) years old and under twenty-one (21) and currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM or ICD equivalent that is current at the date of evaluation. The evaluation must state that the CSED has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

The Department will contract with an ASO and psychological practice to serve as the Medical Eligibility Contracted Agent (MECA) to determine CSED waiver eligibility and manage allotted waiver slots and enrollment into the MCO.

11.11.2 Person Centered Service Plan Team (PCSPT)

The MCO must ensure that each child eligible and enrolled in the MCO through the CSED waiver will have a Person-Centered Service Plan Team (PCSPT) to develop measurable outcomes that guide the child or youth toward less intensive services and transition or graduation from the waiver.

During the initial PCSPT meeting, the child's case manager in conjunction with the PCSPT informs the child and the parents/caregivers/legal representatives of the child of the available resources that may be included in the Person-Centered Service Plan (PCSP). CSED waiver services will emphasize the importance of combining natural supports from the community with professionals to create a PCSP that supports the successful treatment of the member and the parents/caregivers/legal representatives of the child. The PCSPT consists of the child and/or parent/caregiver/legal representative of the child, the child's case manager, representatives of each professional discipline, provider and/or program providing services to the child (inter- and intra-agency), and MCO care coordinator (if requested).

The MCO is required to provide intensive care coordination services, including follow-up and interfacing with the child's provider and medical record reviews from the provider. These activities can also be discussed during the members' Person-Centered Service Plan Team (PCPST) to ensure that appropriate services are being provided after a member's discharge from an inpatient setting.

11.11.2.1 Role of the Case Manager

The MCO will ensure a case manager is assigned to each child eligible and enrolled in the MCO through the CSED waiver. As a safeguard, case management services cannot be provided by the same agency providing any other CSED waiver or Medicaid State plan service to the child. CSED waiver providers will be categorized by type of services offered (i.e., case management) and enrollees may choose their individual providers for each category. Enrollees may change CSED waiver providers at any time with the transfer becoming effective the first day of the month following the request. The child and their parent/caregiver/legal representative will complete a Freedom of Choice form, choosing their case management agency.

The case manager is responsible for engaging the child and the child's family in a partnership of shared decision-making regarding the development and implementation of the child's individual PCSP throughout the child's enrollment in MCO. The PCSP must be based upon person-centered philosophy and is the key document that combines all information from the evaluations to guide the service delivery process as well as information from people who know the child outside the

Income (SSI) benefits at age 18. The PCSPT will also work with the youth to identify other entitlements that would assist the youth post-waiver. This is also the time during which the team will explore what mental health needs the youth may have after his/her twenty-first (21st) birthday and start that transition process with adult services. Whenever possible, the adult services staff will be encouraged to become part of the PCSPT to assure a smooth transition to adult services.

11.11.2.2 Person Centered Service Plan (PCSP) Timeline

A case manager with the chosen case management agency will contact the child and parent/caregiver/legal representative to begin engagement in the PCSP development process prior to the seven (7) day meeting taking place. During this contact, the case manager assures the delivery of the CSED enrollment information describing the waiver services, free choice of providers, and how to report abuse and neglect.

Within seven (7) days of the CSED waiver intake, a mutually agreed upon date will be set for the initial PCSPT meeting. The Case Manager will also schedule and administer the CANS instrument for use in development of the annual PCSP. Although the Case Manager should begin administration of the CANS instrument at the seven (7) day meeting, the expectation is that the CANS will be completed within thirty (30) days of intake to assist with PCSP development. The PCSP shall be developed within seven (7) days and completed within thirty (30) days of intake.

The signed PCSP shall be distributed to all members of the PCSPT within fourteen (14) calendar days.

The case manager shall ensure that a six (6) month PCSP review is completed. If at the child's six (6) month PCSP review, the PCSPT determines he/she has not benefited from waiver enrollment (i.e., no progress has been made on the child's treatment goals and objects), then the PCSPT will refer the child to the ASO to re-determine level-of-care (LOC) placement. Likewise, the PCSPT may determine the child has benefited from waiver enrollment and no longer requires services delivered by this program, at which time discharge planning will commence. Every person must have a re-determination of medical eligibility completed at least annually. The anchor date of the member's annual re-determination is the first day of the month after the initial medical eligibility was established by the MECA. If the reevaluation results in a denials of waiver eligibility, the final decision will be made by BMS.

The MCO shall be responsible for ensuring that the case manager with the case management agency has developed and submitted to the MCO a Person-Centered Service Plan (PCSP) for each CSED member. The MCO shall be responsible for reviewing the ISP prior to service authorization for specified services to ensure appropriateness based on the needs of the child, and in compliance with Chapter 502 of the BMS Provider Manual.

The case manager shall also be responsible for development of a back-up plan for service plans, including the authorization process, in the event a member is unable to access services through the defined primary channel. The MCO must determine whether the back-up plan is sufficient in meeting the needs of the member should it need to be activated and collaborate with the case manager if insufficient.

11.11.3 Additional Home and Community-Based Services (HCBS)

As appropriate, children enrolled in Mountain Health Promise as a result of eligibility for the CSED waiver may receive any of the Medicaid State Plan services and additional CSED waiver

- Generate quarterly incident summary reports for BMS Quarterly Improvement Advisory (QIA) Council.
- Regularly review and analyze incident reports to identify trends and report such trends to BMS.
- Identified incidents must be reported to BMS within twenty-four (24) hours of occurrence.

In addition, the MCO is required to monitor, collect, and report data on all performance measures as defined by the CSED waiver. The MCO will report on authorizations through a monthly dashboard report, delineating specific service types and authorization approvals, denials, and reductions.

11.11.5 CSED Provider Networks

The MCO must interface and outreach with all CSED waiver approved providers and determine their panel and/or capacity for new patients on a monthly basis. The MCO's contracting efforts will include assurances that providers have appropriate and adequate panel capacity. The MCO must monitor its provider network on a quarterly basis.

The MCO is expected to contract with all CSED waiver approved providers within the State, and is required to implement solutions (e.g., Non-Emergency Medical Transportation) to assist enrollees in accessing necessary providers if there is a network gap in certain areas. The MCO is required to perform prospective enrollee forecasting, in accordance with the CSED waiver enrollment requirements, to ensure that the MCO's network is continually sufficient to meet the access needs of the population. The MCO is required to perform intensive care coordination efforts to work with its provider network to ensure enrollees have access at the right time for applicable providers.

The MCO is required to maintain a roster of available providers who are accepting patients, and is required to perform care coordination services to connect members to available providers within the seven (7)-day timeframe from discharge of an inpatient stay or crisis situation. If the MCO cannot identify available providers within the State, to the MCO must provide NEMT and develop ad hoc contracting situations (e.g., Single Case Agreements) with bordering State providers, as necessary. The MCO is expected to continue and/or approve authorizations from out of network providers to promote care continuity in the event that the MCO's current provider network cannot support the service. The MCO is required to coordinate care such that no child should have to wait longer than two (2) weeks for a standard appointment.

The MCO must provide intensive care coordination services, including follow-up and interfacing with the child's provider and medical record reviews from the provider. These activities can also be discussed during the members' PCPST to ensure that appropriate services are being provided after an enrollee's discharge from an inpatient setting.

11.12 Community-based Mobile Crisis Intervention Services

The MCO must provide coverage for enrollees for community-based mobile crisis intervention services in compliance with in the BMS Policy Manual, Chapter 503 Licensed Behavioral Health Centers Appendix 503H Community-Based Mobile Crisis Intervention Services (Crisis intervention services).

referrals for that service. If the provider scores a zero (0) on any safety related service during any review, the service will be automatically closed for the provider.

The MCO must provide a report on each provider assessment to BSS outlining the results of each of the services under review, the methodology by which the provider was reviewed, the scores for each service area, provider strengths, weaknesses (opportunities for improvement), documentation that all staff have met background check, licensure and educational requirements, as applicable, and recommendations for next steps to improve provider processes. BSS shall take appropriate action to provider contracts based on the feedback submitted by the MCO. The MCO must provide its reports to BSS within thirty (30) calendar days of completion of the assessment and must coordinate with BSS throughout the process to expedite any necessary action.

The MCO must continuously monitor the utilization of services and provide monthly reports, due fifteen (15) days after the conclusion of the month, that highlight geographic areas in which there is a high utilization of services required with low provider enrollment (e.g. providers must travel greater than forty-five (45) minutes to render services) or the use of providers that are not most geographically appropriate in the requested service area. The report must provide recommendations to BSS on how to address such service gaps and misutilization of providers.

12.5 Authorization Requirements

The MCO must establish a bidirectional IT solution by which the MCO can receive SNS authorization requests entered by the CPS caseworker into the State's FACTS system and return authorization approvals. The MCO must authorize services entered into the system within forty-eight (48) hours of entry for those authorized automatically. Those services that require care management review must be returned within five (5) business days of receipt of all additional necessary information from the provider. The MCO must not require authorization for emergency services. The CPS caseworker shall retain the authority to select the vendor to be used for SNS, however, the MCO must be available to assist the worker with identification of a provider, if needed.

The MCO must authorize the services for the scope and duration of the request by the CPS caseworker, as appropriate, and may reauthorize services pending review of progress by the enrollee. In the event the duration of services is not outlined within the request, the MCO must coordinate with the CPS caseworker to determine the most appropriate level of service for the initial authorization. During contract year one (1), the MCO must utilize the existing BSS Utilization Management Manual for its authorization review process.

The MCO shall develop a process to ensure the most appropriate socially necessary services (SNS) are used to meet the enrollee's and/or the enrollee's family needs. The MCO must use the family service plan (FSP) and individualized service plan (ISP) information, as applicable from the Department caseworker, to determine the most appropriate SNS.

The MCO shall develop, review, and apply utilization management guidelines to be approved by the Department for SNS services. The MCO shall establish utilization management processes for enrollees, including, but not limited to social necessity review, approvals, and denials. All utilization guidelines must meet Department-specified standards for utilization management.

The MCO must also establish a provider portal by which the provider may review their authorizations to determine the scope and duration of services authorized by the MCO. Authorization information must be uploaded within twenty-four (24) hours of approval. In

5. Provides discharge planning and family-based aftercare support for at least six (6) months post-discharge;
6. Is licensed in accordance with the title IV-E requirements (section 471(a)(10) of the Social Security Act) and is accredited by any of the following independent, not-for-profit organizations: The Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA), or any other independent, not-for-profit accrediting organization approved by HHS; and
7. Has registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice as defined by state/tribal law, are on-site according to the treatment model, and are available twenty-four (24) hours a day and seven (7) days a week. This requirement must not be construed as requiring a QRTP to acquire nursing and behavioral health staff solely through means of a direct employer to employee relationship.

13.2.1 QRTP Placement Assessment

The MCO must confirm that the Department's contractor has completed an independent assessment of the QRTP placement within thirty (30) days after placement in the QRTP. A "qualified individual" must assess a child to determine the appropriateness of a placement in a QRTP within thirty (30) days after the placement is made for purposes of approving the case plan and the case system review procedure for the child (Section 475A(c) of the Social Security Act). A "qualified individual" is defined as a trained professional or licensed clinician who is not an employee of the agency, and who is not connected to, or affiliated with, any placement setting in which children are placed by the agency.

The "qualified individual" must:

1. Assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool approved by the Secretary;
2. Determine whether the needs of the child can be met with family members or through placement in a foster family home or, if not, which allowable Child Care Institution (CCI) setting would provide the most effective and appropriate level of care for the child in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child;
3. Develop a list of child-specific short- and long-term mental and behavioral health goals; and
4. Work in conjunction with the child's family and permanency team (further described below) while conducting and making the required thirty (30) day assessment.

If the "qualified individual" determines the child should not be placed in a foster family home, he/she must specify in writing:

1. The reasons why the child's needs can't be met by the family or in a foster family home (a shortage of foster family homes is not an acceptable reason for determining the child's needs cannot be met in a foster family home); and

- The most recent versions of the evidence and documentation submitted for the most recent status review or permanency hearing; and
- The signed approval of the head of the title IV-E agency for the continued placement of the child in that setting

The MCO shall be responsible for providing to BSS any data necessary for completion of this report.

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 MCO must locate appropriate placements for children dually involved in the child welfare and juvenile justice systems regardless of their Medicaid status.

13.3 Focus Groups

The MCO must conduct at least four (4) focus groups and two (2) surveys throughout the year with youth, families and foster parents that have received services within a residential treatment facility. The focus groups and surveys should be used as an opportunity to provide the Department with feedback on where services are being most impactful, so programmatic changes may be made to improve the overall health of the program.

The MCO must collaborate with the BSS to establish key topics and targeted issues, and related questions, for each focus group and survey to ensure the most useful information is being collected.

13.4 Provider Requirements

The MCO must ensure that Children's Residential Treatment Facilities and Emergency Shelters adhere to the requirements of their contract with BSS through collaboration with the Department of this oversight. The MCO must monitor and validate that all services, referral standards, admission standards, discharge standards, personal needs of youth, medical service requirements, and reporting requirements are adhered to. Standards for both residential providers and emergency shelter providers are outlined within the BSS Provider Agreements.

14. PERSONAL CARE SERVICES

The MCO is not required to cover personal care services for enrollees. These services will remain covered under fee-for-service.

15. COMMUNITY ENGAGEMENT REQUIREMENTS

The MCO is required to create a voluntary advisory group of foster, adoptive, and kinship parents, which must meet every six (6) months, to discuss issues they are encountering with the MCO and recommend solutions. The MCO must report to the Department as requested on the recommendations of the advisory group and address how and why procedures have or have not changed based on those recommendations. This report must be submitted by the Department to the Secretary and the Legislative Oversight Commission on Health and Human Resources Accountability and the public in a timely fashion and must be available upon request.

The MCO shall develop a policy for training new foster or kinship families about the child's medical needs, and assist them with coordinating care for the child as part of care management responsibilities.

18. SIGNATURES

Each party accepts the Agreement's terms as formally acknowledged below:

West Virginia Department of Human Services

Signature: Susan H Deel

Printed Name: Susan H. Deel

Title: Director, Center for Managed Care

Date: 6/28/24

State of West Virginia, Department of Administration Purchasing Division

Signature: Tara Lyle

Printed Name: Tara Lyle

Title: Buyer Supervisor

Date: 9/17/2024

Managed Care Organization

Signature:

Printed Name: Todd R. White

Title: CEO

Date: 6-14-24

Row	Medical Service	Definition	Scope of Benefit	Limitations on Services
2	Cardiac Rehabilitation	A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore enrollees with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department.	Supervised exercise sessions with continuous electrocardiograph monitoring. The medically necessary frequency and duration of cardiac rehabilitation is determined by the enrollee's level of cardiac risk stratification.	
3	Children's Residential Services	Services provided by Children's Residential Facility	All children's residential providers and services.	NA
4	Chiropractor Services	Services provided by a chiropractor consisting of manual manipulation of the spine.	Manipulation to correct subluxation. Radiological examinations related to the service.	Certain procedures may have service limits.
5	Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a clinic (that is not part of a hospital) on an outpatient basis.	General clinics, birthing centers, and health department clinics, including vaccinations for children.	

Row	Medical Service	Definition	Scope of Benefit	Limitations on Services
9	Gender Affirmation for Gender Dysphoria	Gender Dysphoria is a condition defined in the DSM in which a person experiences clinically significant distress or impairment because there is an incongruence between their biological sex and gender identity. Gender affirmation surgeries are covered for individuals diagnosed with gender dysphoria and meeting certain criteria to align their biological sex with their gender identity.	All treating, rendering, ordering, or referring providers. Male to Female (MTF) and Female to Male (FTM) gender affirmation surgeries when conditions of coverage are met and prior authorization is obtained.	Enrollees must be twenty-one (21) years or older prior to being considered for this procedure. No surgery should be performed while a patient is actively psychotic. Contraindications to surgery include an accompanying psychiatric disorder, severe environmental challenges, failure to remain in a cross-sex role during the trial period, illicit drug use, or a lack of Gender Dysphoria diagnosis.
10	Handicapped Children's Services/ Children and Youth with Special Health Care Needs Services	Specialty services provided to handicapped children and those who may be at risk of handicapping conditions.	Provides linkage and coordination of services to all WV children with special needs and limited direct medical services, equipment, and supplies to those families that meet financial and other program eligibility requirements.	Services are provided to children under twenty-one (21) with the following diagnoses, but not limited to: cystic fibrosis; myelocystomeningocele/ myelodysplasia; congenital heart defects; craniofacial deformities; seizure disorders; and metabolic disorders.
11	Home Health Care Services	Nursing services, home health aide services, medical supplies suitable for use in the home.	Provided at the enrollee's place of residence on orders of a physician.	Residence does not include hospital nursing facility, ICF/MR, or state institution. Certain suppliers have service limits.

Row	Medical Service	Definition	Scope of Benefit	Limitations on Services
15	Inpatient Rehabilitation	Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals.	Services that are medical inpatient rehabilitation services for Medicaid eligible individuals, and general medical outpatient services which meet certification requirements of the Office of Facility, Licensure and Certification.	
16	Laboratory and X-Ray Services. Non-Hospital	Laboratory and x-ray services provided in a facility other than a hospital outpatient department.	All laboratory and x-ray services ordered and provided by or under the direction of a physician. Includes laboratory services related to the treatment of substance abuse.	Must be ordered by physician. Certain procedures may have service limits.
17	Nurse Practitioners' (NP) Services	Services provided by a nurse midwife, nurse anesthetist, family, or pediatric NP.	Specific services within specialty.	Certain procedures may have service limits.
18	Other Services Speech Therapy Physical therapy Occupational Therapy	NA	Treatment or other measures provided by speech, physical or occupational therapists to correct or ameliorate any condition within the scope of their practice.	Hearing aid evaluations, hearing aids, hearing aid supplies, batteries and repairs are limited to enrollees under age twenty-one (21). Certain procedures may have service limits or require prior authorization. Augmentation communication devices limited to children under twenty-one (21) years of age and require prior approval.

Row	Medical Service	Definition	Scope of Benefit	Limitations on Services
23	Pulmonary Rehabilitation	Individually tailored multidisciplinary approach to the rehabilitation of enrollees who have pulmonary disease.	One-on-one therapeutic procedures to increase strength or endurance of respiratory muscles and functions.	
24	Right from the Start Services	Services aimed at early access to prenatal care, lower infant mortality, and improved pregnancy outcomes.	Care coordination and enhanced prenatal care services.	Pregnant women (including adolescent females) through twelve (12) month postpartum period and infants less than one (1) year of age. No prior authorizations can be required for RFTS services.
25	Rural Health Clinic Services: Including Federally Qualified Health Centers	Physician, physician assistant (PA), and NP providing primary care in a clinic setting.	Physician, PA, NP, nurse midwife services, supplies, and intermittent visiting nurse care in designated shortage areas.	
26	Tobacco Cessation	Treatment for tobacco use and dependence.	Diagnostic, therapy, counseling services, and quit line services. The children's benefit also includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits.	
27	Transportation, Emergency	Transportation to secure medical care and treatment on a scheduled or emergency basis.	Emergency ambulance and air ambulance.	Emergency transportation provided to the nearest resource. By most economical means determined by patient needs.

Table A-3: MCO Covered Behavioral Services *

Row	Behavioral Service	Definition	Scope of Benefits	Limitations on Services
1	Behavioral Health Rehabilitation for Individuals Under Age Twenty-One (21), Psychiatric Residential Treatment Facility	Behavioral health rehabilitation performed in a children's residential treatment facility.	Diagnosis, evaluation, therapies, and other program services for individuals with mental illness, mental retardation, and substance abuse.	Procedure specific limits on frequency and units.
2	Behavioral Health Outpatient Services	Behavioral health clinics, behavioral health rehabilitation, targeted case management, psychologists, and psychiatrists. (Emergency room services are included in the MCO benefits package.)	Diagnosis, evaluation, therapies, including Medication Assisted Treatment, and other program services for individuals with mental illness, mental retardation, and substance abuse.	Procedure specific limits on frequency and units. Only assertive community treatment (ACT) providers certified by the Department or the Bureau of Behavioral Health and Health Facilities may provide ACT services. Excludes children's residential treatment. Services only covered for children and youths, ages 18-21 years.
3	Psychological Services	Services provided by a licensed psychologist in the treatment of psychological conditions.	Evaluation and treatment, including individual, family, and group therapies. Psychological services may be delivered using telehealth.	Evaluation and testing procedures may have frequency restrictions.

Row	Behavioral Service	Definition	Scope of Benefits	Limitations on Services
8	Serious Emotional Disturbance Waiver Services	Provides children with some mental health conditions, special intensive support to help them remain in their homes and communities	To be defined, pending approval by CMS	To be defined, pending approval by CMS.

* An outpatient follow-up session immediately following the discharge from the facility is an MCO covered benefit.

Medicaid Benefits Covered Under FFS Medicaid

The following services are excluded from the MCO's capitation rates but will remain covered Medicaid services for persons who are enrolled with the MCO. The State will continue to reimburse the billing provider directly for these services on a FFS basis. The State may consider the use of specialized carve-outs in the future.

Table A-4: Medicaid Benefits Covered Under FFS Medicaid

Row	Medical Service	Definition	Scope of Benefits	Limitations on Services
1	Abortion	Pregnancy termination determined to be Medically Necessary by the attending physician in consultation with the patient in light of physical, emotional, psychological, familial, or age factors (or a combination there of) relevant to the well-being of the patient.	Drugs or devices to prevent implantation of the fertilized ovum and for medical procedures necessary for the termination of an ectopic pregnancy.	Written physician certification of medical necessity. All Federal and State laws regarding this benefit must be adhered to.
2	Early Intervention Services for Children Three (3) Years and Under	Early intervention services provided to children three years and under through the Birth to Three (3) program.	Services provided by enrolled Birth to Three (3) providers.	

Row	Medical Service	Definition	Scope of Benefits	Limitations on Services
6	Personal Care for Individuals Enrolled in the Aged/Disabled Waiver	Community care program for elderly.	Assistance with activities of daily living in a community living arrangement. Grooming, hygiene, nutrition, non-technical physical assistance, and environmental.	Limited on a per unit per month basis. Physicians order and nursing plan of care is required.
7	Prescription Drugs	Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance.	Prescription drugs dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children to age twenty-one (21), and prenatal vitamins.	Not Covered: Drugs for weight gain, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Hemophilia blood factors are covered by Medicaid FFS. Drugs and supplies dispensed by a physician acquired by the physician at no cost are not covered. Hemophilia-related clotting factor drugs and Hepatitis-C virus-related drugs are covered by FFS.
8	School-based Services	Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting.	Services provided in a school-based setting.	Limited to individuals under age twenty-one (21). Refer to the FFS Medicaid provider manuals for an explanation of service limitations.

Row	Medical Service	Definition	Scope of Benefits	Limitations on Services
12	Tubal Ligation	Family planning service provided to individuals of childbearing age to permanently prevent pregnancy.	In accordance with West Virginia Code §9-5-12, the Department of Human Services shall make payment for tubal ligation without requiring at least 30 days between the date of informed consent and the date of the tubal ligation procedure.	Any licensed doctor providing these services must be compliant with the Federal Social Security Act 42 CFR §441, Subpart F – Sterilizations, §441.255 and §441.256 requirements, which requires informed consent and medical necessity.

Abortion Services

Under the terms of this Contract, MCO may not reimburse Medicaid providers for the services provided enrollees under any reported and verified abortion CPT codes. Abortion Services will be reimbursed under FFS Medicaid.

Table A-5: Additional HCBS Covered by the MCO Under the CSED Waiver

Row	Service	Definition	Scope of Benefits	Limitations on Services
1	Assistive Equipment	An item, piece of equipment or product system that is used to address a member's needs that arise as a result of his/her serious emotional disturbance (SED).	The equipment should increase, maintain, or improve functional capabilities of the member, assist him/her to avoid an out-of-home placement. This category can also include the evaluation of assistive equipment needs of a member, as well as costs of acquisition training.	Up to $500.00 Per Service Year Plan. In combination with Specialized Therapy.

Row	Service	Definition	Scope of Benefits	Limitations on Services
4	Mobile Response	Twenty-four (24)-hour services designed to respond immediately to issues that threaten the stability of the member's placement and his/her ability to function in the community as determined by the family.	This service is intended to be of very short duration and primarily to link to other services and resources. This service may only be delivered in an individual, one-to-one session. This service includes: de-escalation, issue resolution support, and the development of a stabilization plan for any additional services that are needed to resolve the immediate situation. If a member exceeds the fourteen (14)-hour cap on services per week, the MCO shall refer to CSHCN as necessary to allow continued services.	Up to fourteen (14) hours per week.
5	Day Habilitation: Independent Living/Skills Building (Ages 15-21)	Services to facilitate' the member's community inclusion and remaining in his/her home. Services include therapeutic recreation, job development, and independent living/skills building, and are provided in local community settings (such as libraries, stores, parks, city pools, etc.).	Independent living/skills building can be related to activities of daily living, such as personal hygiene, household chores, and socialization, if these skills are affected by the member's SED. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, employment skills, self-advocacy and informed choice necessary to successfully function in the home and community.	Up to forty (40) hours per week. In combination with Supported Employment and Job Development.

Row	Service	Definition	Scope of Benefits	Limitations on Services
7	In-Home Family Therapy	Counseling and training services for the member and family provided by a licensed mental health professional.	This service includes individual and family therapy in the family home and should assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the member in relation to his/her mental illness and treatment, such as development and enhancement o' the family's problem-solving skills, coping mechanisms, and strategies for' the member's symptom/behavior management.	Up to two (2) sessions per day in combination with both codes.
8	In-Home Family Support	Services to allow the member and family to practice and implement the coping strategies introduced by the in-home therapist.	The family support worker works with the member and family on the practical application of skills and interventions that will allow the member and family to function more effectively. The family support worker assists the family therapist by helping the parent/child communicate their concerns; providing feedback to the therapist about observable family dynamics; helping the family and youth implement changes discussed in family therapy and/or parenting classes; supporting, and encouraging new parenting techniques; helping parents learn new parenting skills specific to meet the needs of their child; participating in family activities and supports parents in applying specific and on-the-spot parenting methods in order to change family dynamics.	Up to two (2) hours per day.

Row	Service	Definition	Scope of Benefits	Limitations on Services
11	Respite Care (In and Out-of- Home)	Services provided to temporary relieve' the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period.	In-Home Respite must be provided i' the member's home, which is defined as a natural family home or a certified therapeutic foster care home. Out-of-Home Respite must be provided by a certified therapeutic foster care home. Both types of respite may be provided in the local public community.	Up to 2,304 units per year combined with in/out-of-home.
12	Peer Parent Support	Services are designed to offer support to the parent/guardian of the member with SED. The services are geared toward promoting parent/guardian empowerment, enhancing community living skills, and developing natural supports.	This service connects the parent/caregiver with a parent(s) who are raising or have raised a child with mental health issues and are personally familiar with the associated challenges.	Up to two (2) hours per week.
13	Specialized Therapy	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of a member's needs that arise as a result of his/her SED.	The service is intended to assist the member in acquiring the knowledge and skills necessary to understand and address these treatment needs, e.g., developing and enhancing problem-solving skills, coping mechanisms, strategies for the member's symptom/behavior management.	Up to $500.00 Per Service Year Plan. In combination with Assistive Technology.

APPENDIX B: OVERVIEW OF WEST VIRGINIA'S SFY 2023 PAYMENT METHODOLOGY AND CAPITATION RATES FOR MOUNTAIN HEALTH PROMISE

(under a separate cover)

3. Examples of general health education materials include, but are not limited to: condition-specific brochures, letters or phone calls, text messages, mobile applications, websites, newsletters, or posters developed by the World Health Organization, Centers for Disease Control, American Diabetes Association, American Heart Association, American Dental Association, American Medical Association, American Cancer Society, American Lung Association, or the QUIT LINE and do not require BMS review and approval.

General Marketing and Member Materials Policies

MCO marketing and member materials used by the MCO must meet the requirements below.

A. Clarity of the Material's Purpose

To meet the clarity of purpose requirement, all MCO materials, including telephonic scripts, text messages, voice-messages, and other digital communications, must be written, structured, or designed so that the purpose of the material is clear and immediately evident to the intended audience. The MCO should promptly state the purpose of telephone calls when communicating by telephone or leaving voice-messages. The MCO must include appropriate contact information for the MCO whereby the public or a current enrollee may inquire about the material's content.

B. Readability of the Material

To meet the readability requirement, all MCO materials must have an appropriate format and reading grade level.

Regarding format, all MCO paper and electronic written materials must use a conspicuously visible font size (no smaller than twelve (12)-point font or larger), and whenever practicable, include descriptive or summary text headings to ensure meaningful access for those limited by low-English proficiency and those limited by low-reading proficiency.

Regarding reading level, all MCO materials must be written at or below a sixth (6^{th})-grade level (Grade 6.9 or below). The MCO must measure the reading level of its materials using an assessment tool or software program which is common to the industry and produces a verifiable score report that the MCO will retain for its records. Any material submitted for BMS approval must contain the reading level assessment and a statement from the MCO certifying that the material complies with the reading level standard set forth herein, unless an exemption has been authorized by BMS.

C. Translation and Accessibility Resources

To meet the translation and accessibility resource requirement, all MCO materials must provide, either as part of the material or via an enclosure, instructions for obtaining the material in an alternate language, or through auxiliary aids and services like sign language communication, oral interpretation, oral translation, and any additional accessibility resources offered by the MCO.

D. Social Determinants of Health Resources

If applicable, MCO materials must inform the intended audience how they may access community-based resources to assist with SDoH needs.

E. Privacy Protections

All MCO materials transmitted in printed form must be packaged in a manner that conceals the content of the MCO communication from public view. This standard applies to letters, notices,

This list is not intended to be exhaustive, and the MCO should ensure its marketing activities comply with all federal and state laws and regulations.

The following prohibitions are applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. Distributing Marketing materials without prior Department approval;
2. Using the word, "Mountain," or phrase, "Mountain Health," "Health Bridge", except when referring to Mountain Health Trust, West Virginia Health Bridge, or other State programs;
3. Distributing Marketing materials written above the sixth (6^{th}) grade reading level (Grade 6.9 or below), unless approved by the Department;
4. Offering gifts valued over fifteen dollars ($15) or seventy-five dollars ($75) annually to potential enrollees;
5. Providing gifts to providers for the purpose of distributing them directly to the MCO's potential enrollees or current enrollees;
6. Directly or indirectly, engaging in door-to-door, email, text, telephone, and other Cold Call Marketing activities;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);
9. Making any assertion or statement (orally or in writing) that the MCO is endorsed by CMS, a federal or state government agency, or similar entity;
10. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone, or electronic means of communication;
11. Inducing or accepting an enrollee's MCO enrollment or MCO disenrollment;
12. Using terms that would influence, mislead, or cause potential enrollees to contact the MCO, rather than the Enrollment Broker, for enrollment;
13. Portraying competitors in a negative manner;
14. Using absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to the Department;
15. Making any written or oral statements containing material misrepresentations of fact or law relating to the MCO's plan or the Medicaid program, services, or benefits;
16. Making potential enrollee gifts conditional based on enrollment with the MCO;
17. Charging enrollees for goods or services distributed at MCO or Medicaid events;
18. Charging enrollees a fee for accessing the MCO's website;
19. Influencing enrollment in conjunction with the sale or offering of any private insurance;
20. Tying enrollment in the Medicaid MCO with purchasing (or the provision of) other types of private insurance;

5. Any enrollee complaints received through the social media sources must be processed and resolved through the general complaint intake system.

B. Social Media Prohibitions

The following prohibitions are applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. Posting or sending any protected private information on social media source;
2. Advertising on social media platforms that entail direct communication with potential enrollees. This list includes, but is not limited to Instagram, Twitter, Teams, Zoom, Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services;
3. Responding to any comments on social media posts from potential enrollees except when to provide general response, such as MCO phone number, links to the MCO web site or the enrollment broker phone number;
4. Partaking in individual communication on social media outlets;
5. Requesting followers or adding individuals as friends (i.e., friends on Facebook, followers on Instagram or Twitter); and
6. Tagging individuals on social media source.

MCO Events and In-Person Marketing

If the MCO, its agents, Subcontractors, MCO providers, or any individual, organization, or entity connected to the MCO, whether paid or unpaid (i.e. volunteers), engages in or participates in-person at an event, either physically or by digital communication technologies (i.e. Zoom or other video conferencing methods) on behalf of the MCO, the MCO must ensure that the participant's conduct is not solicitous of enrollment and that any MCO materials distributed by or through the participant at such an event comply with the Marketing and Member Materials Policies contained in the MCO Contract

Marketing Representative Training

The MCO is required to inform any agents, subcontractors, providers, and/or any individual, organization, or entity connected to the MCO, whether paid or unpaid, of these Marketing and Member Material Policies prior to such person's participation in any event or in-person marketing activity on behalf of the MCO.

Event Handouts and Other MCO Materials

All materials used at MCO events or for in-person Marketing must meet the requirements list herein for similar marketing materials.

Reporting and Investigating MCO Marketing Violations

The MCO must establish a process to ensure fair and consistent investigation of alleged violations of the Department's Marketing Policies.

Upon written receipt of any alleged MCO violation(s) from the Department, the MCO must:

APPENDIX D: SUMMARY OF MCO REPORTING REQUIREMENTS

All MCO reports submitted under this Contract must reflect program-related data only unless otherwise requested by the Department. For each submission, the MCO must submit the certification concurrently using the format included as Appendix E of this Contract.

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
Quarterly Reporting					
1: Enrollment and Membership Report		X			Within forty-five (45) calendar days of end of quarter (by the fifteenth (15th) day of the second (2nd) month following the end of the reporting period)
2: Provider Network Status Report		X			
3: Medical Claims Processing		X			
4: Experience Summary		X			
5: Lag Tables		X			
6: Summary of Claims Paid Outside Encounter Data and Sub-Capitation Arrangements		X			
7: Member and Provider Services Functions		X			
8: Statement of Revenue and Expenses		X			
9: Out-of-Network Utilization Report		X			
10: Member Access to Care		X			
11: Provider Complaints		X			
12: Value-added Services		X			
13: Member Appeals and Grievances		X			
14: Provider Credentialing		X			
Quality Reporting					
Written Description of PIPs and Results			X		July 15th
PIP Progress Report		X			Within one-hundred twenty (120) calendar days of end of quarter
HEDIS			X		On or before July 14th (audited)
QAPI Annual Evaluation Report Including Status and Results			X		On or before June 15th

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
Provider-Preventable Conditions			X		July 15th
MLR Reports and Calculations			X		Eight (8) months after the end of the SFY
Recovery of All Overpayments Report (included in the FWA Report listed under Other Federal and State Reporting below)	X				By the fifteenth (15th) day of the month
IMD Mid-month Report	X				Submit on the sixteenth (16th) day of the month
IMD EOM Report	X				Submit on the last day of each month
Hospital Paid Claims Report		X			Emailed to OAMR no later than the seventh (7th) day of each month after the quarter ends, or the following Monday if the seventh (7th) day falls on a weekend
Cash Disbursement Journal (CDJ)	X				By the fifteenth (15th) day of the following month
Other State and Federal Required Reporting					
State and Federal Report Attestation: a. Hysterectomies and Sterilizations b. Sexually Transmitted Diseases c. Tuberculosis d. Communicable Diseases			X		Submit attestation by October 1st
Data Certification Report	X				Fifteenth (15th) day of the following month
Encounter Certification Report	X				Fifteenth (15th) day of the following month
EPSDT Services and Reporting		X			Forty-five (45) days after each quarter
Business Continuity Plan (BCP)			X	X	On or before October 1st
BCP Review Report			X	X	At least annually, within five (5) business days of test completion
Information Security Plan				X	Within ten (10) business days of Department written request
Health Information Systems Strategy				X	

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
Parity in Mental Health and Substance Use Disorder (SUD) Benefits Compliance Plan			X		On or before June 30th
SUD Utilization/Finance Report	X				By the 10th of the following month
PRTF and Children's Residential Services and Demographic Report	X				By the fifteenth (15th) day of the following month
Weekly Member Status Report.				X	On Friday of each week
SNS underserved areas of the State where they additional SNS providers are needed	X				Fifteenth (15th) day of the following month
1915 (c) CSED Waiver-Minimum required reports: • Prior authorization reporting; • Grievances, appeals, and denials reporting; • Member satisfaction reporting; • Staffing/training reports; • Service plan reporting; • Critical incident and death reporting; • Claims reporting; Any additional waiver reports.	X	X	X	X	As defined by the CSED Waiver Program
CSED Waiver DNR Report	X				Fifteenth (15th) day of the following month
MHP Outreach and Engagement Metrics	X				Fifteenth (15th) day of the following month
§9-5-27 MHP Report			X		On or before June 15th
Disclosure of Legal Proceedings and Related Events				X	Within thirty (30) calendar days after becoming aware of a matter
Provider Directory			X		October 31
Managed Care Program Annual Report (MCPAR) Supplemental Report			X		On or before October 31.

APPENDIX E 2: DATA CERTIFICATION FOR MONTHLY AND WEEKLY ENCOUNTER DATA FILE SUBMISSION

STATE OF WEST VIRGINIA

Date Of Data Submission: MM/DD/YYYY

Managed Care Program Type: _____

Data Submitted to: _____

Name of Agency Official

_____

Agency/Division

Method of Data Transmission: ___Electronic ___Hard Copy

I hereby certify that, in my belief and to the best of my knowledge (based on all information available to me at the time such data was submitted), the data contained in the **MCO MedEncs YYYYMM YYYYMM.txt** file submission by **MCO Name** was accurate, complete, and truthful, and that it had no known or suspected material limitations or imperfections unless described in detail in a statement provided with that submission.

I further certify that I have authority* to sign this certification on behalf of **MCO**.

Certified by*:

_____

Signature

_____

Name

_____

Title

MM/DD/YYYY

Date

^ Data certification must be submitted concurrently with the certified data (42 CFR §438.606(c)).

* Certification must be signed by the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for and who reports directly to the MCO's CEO or CFO (42 CFR §438.606(a)).

#	Program Non-Performance	Measurement Period	Liquidated Damages
7	Failure to meet provider credentialing requirements, including background screening requirements, specified in Article III, Section 3.1, Provider Qualification and Selection.	Ongoing	$1,000 per incident of non-compliance.
8	Failure to comply with the marketing requirements, or engagement in prohibited marketing practices. Failure to meet all social media marketing requirements, or engagement in any prohibited social media practices. Article III, Section 4.1 and Appendix C.	Ongoing	$1,000 per each incident of non-compliance.
9	Failure to pay ninety percent (90%) of total clean claims within thirty (30) calendar days as required in Article III, Section 3.7.	Monthly	Up to $10,000 per month for any month in which the MCO fails to meet clean claims timely processing requirements.
10	Failure to pay eighteen percent (18%) annual interest on the same date as an in-network or out-of-network provider clean claim that remained unpaid beyond the thirty (30) calendar day claims payment deadline. Article III, Section 3.7, Timely Payment Requirement.	Quarterly	$500 per each in-network clean claim for which the interest remained unpaid on the same date as a claim's payment.
11	Failure to provide timely MCO covered services as described in Appendix A of this Contract when, in the determination of the Department, such failure results in actual harm to an enrollee or places an enrollee at risk of imminent harm.	Ongoing	$7,500 per business day for each incident of non-compliance.
12	Failure to make at least ninety-five percent (95%) of authorization decisions and provide written notice within the timeframes outlined in in Article III, Section 6.4.	Quarterly	$250,000 for each quarter in which the threshold is not met
13	Failure to administer enrollee copayments, including charging excess copayments for covered services, as determined by the Department and outlined in Article III, Section 4.9.	Ongoing	$100 per each copay incident imposed in error.
14	Failure to hold or improperly release funds subject to a credible allegation of fraud payment hold.	Ongoing	Amount held or released improperly.

APPENDIX G: MEDICAL LOSS RATIO (MLR) REPORTING METHODOLOGY

Appendix G of this Contract outlines the requirements for the MLR reporting and for calculating any program rebate amount that may be due to the Department in the event the MCO does not meet the minimum eighty percent (85%) MLR standard as provided by Article III, Section 8.2 of this Contract. In addition to reviewing this Appendix, MCOs are advised to review the following CFR provisions prior to completing the MLR report: 42 CFR §438.8; 438.604; and §438.606. CMCS Information Bulletins; CCIIO Technical Guidance; the comments and responses in the final rule dated May 6, 2016; the updated final rule comments and responses dated July 1, 2022; along with any other applicable federal and state regulations.

General Standards for Reporting

The MCO must demonstrate its ongoing Contract compliance with the MLR standards, as set by Article III, Section 8.2 of this Contract. The MCO must complete and submit the MLR Financial Reports to the Department, using the following schedule:

1. As required by the Department during the rate-setting and supplemental data request process;
2. Annually, eight (8) months following the end of the State Fiscal Year (SFY) for CMS submission; and
3. Following any instance where BMS makes a retroactive change to the capitation payments for a MLR reporting year in which the MLR report has already been submitted to BMS, the MCO must re-calculate the MLR for each MLR reporting year affected by the change and resubmit the reports to BMS per 42 CFR §438.
4. Following any instance where the MCO identifies an issue impacting a previously filed MLR Financial Report which is material, the MCO should communicate the issues and its impact to BMS and request to amend the previously filed MLR Financial Report.

The MCO must require any third-party vendor providing claims adjudication or HCQI activities to provide all underlying data associated with MLR reporting to the MCO within one hundred and eighty (180) calendar days of the end of the MLR reporting year or within thirty (30) calendar days of being requested by the MCO, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting per 42 CFR §438.8(k)(3). The MCO must maintain and make available to the Department upon request any data used to calculate MLRs and MLR rebates under this Appendix together with all supporting information required to determine the methods for calculations outlined in this Appendix.

Certification of Accuracy

42 CFR §438.606 and 42 CFR §438.8(n) require that the MLR report submission be certified that based on best information, knowledge, and belief, the data, documentation, and information provided in the report is accurate, complete, and truthful. The certification must be signed by the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification. MLR report submissions without the required certification will not be accepted.

- Withholds from payments made to network providers;
- Claims that are recoverable for anticipated coordination of benefits;
- Claims payments recoveries received as a result of subrogation;
- Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;
- Changes in other claim-related reserves;
- Reserves for contingent benefits and the medical claim portion of lawsuits;
- The amount of incentive and bonus payments made, or expected to be made, to network providers;
- The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include fraud prevention activities. MCO calculation and reporting of the fraud prevention activities as adopted for the private market at 45 CFR §158 is currently suspended for implementation by CMS;
- Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds; and
- Additional elements are required by the Department.
- Changes in FQHC/RHCs reimbursement rates and re-processing should be reported on the MLR in the period in which they are paid.

Incurred medical claims and expenses may not include:

- Overpayment recoveries received from network providers;
- MCO prescription drug rebates received and accrued, if any;
- Amounts paid to third party vendors for secondary network savings;
- Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management;
- Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 CFR §438.3(e) and provided to MCO enrollees;
- Fines and penalties assessed by regulatory authorities;
- Amounts paid to the Department as MLR remittance;
- Amounts paid to network providers as pass-through payments; and
- Additional elements are required by the Department.

Activities that Improve Health Care Quality (Numerator)

The MCO must account for expenditures for activities that improve health care quality, as described in this Appendix. The MCO must clearly document the actual expenses reported for HCQI. This includes detail to support how the reported expenses qualify for HCQI at the plan level. Reported vendor expense should not exceed the vendor's incurred cost of providing the

iii. Quality reporting and documentation of care in non-electronic format.

iv. Health information technology to support these activities.

v. Accreditation fees directly related to quality-of-care activities.

b. Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

i. Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

ii. Patient-centered education and counseling.

iii. Personalized post-discharge reinforcement and counseling by an appropriate health care professional.

iv. Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

v. Health information technology to support these activities.

c. Improve patient safety, reduce medical errors, and lower infection and mortality rates. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

i. The appropriate identification and use of best clinical practices to avoid harm.

ii. Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.

iii. Activities to lower the risk of facility-acquired infections.

iv. Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

v. Health information technology to support these activities.

d. Implement, promote, and increase wellness and health activities. Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include:

i. Wellness assessments;

ii. Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

iii. Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

iv. Public health education campaigns that are performed in conjunction with State or local health departments;

v. Actual gifts or incentives that are not already reflected in claims;

Contract and that are designed for use by MCO, its providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

1. Making incentive payments to providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by the United States Department of Health and Human Services (HHS), to the extent such payments are not included in reimbursement for clinical services as defined by this Appendix;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law.
5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.
6. Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic health records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management.
7. Reformatting, transmitting, or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Denominator

The MCO denominator for an MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the MCO's premium revenue minus the MCO's Federal, State, and local taxes and licensing and regulatory fees; aggregated in accordance with each program reported.

Premium revenue must include at least the following:

- State capitation payments, excluding pass-through payments made under 42 CFR §438.6(d);

Rebating Capitation Payments: 85% MLR Standard is Not Met

For each MLR reporting year, the MCO must provide a rebate to the Department if the MCO does not meet the eighty-five percent (85%) MLR standard requirement. The MCO is not subject to MLR rebating during the initial contract term, March 1, 2020 to June 30, 2020, but is required to provide MLR reporting to the State for review.

In accordance with Article III, Section 8.2.2, an MLR percentage of less than eighty-five percent (85%) must be one hundred percent (100%) reimbursable to the State. The State shall reimburse the MCO eighty percent (80%) of costs incurred that exceed ninety-five percent (95%) MLR for those services meeting the reporting definition.

The MCO rebate amounts will be assessed by the Department using the MLR calculations provided within the SFY MLR Report submitted to the Department by the MCO. The MLR rebate, if any, is due to the Department in full sixty (60) calendar days after the Department notifies the MCO in writing of any MLR rebate amount due.

If MCO determines that payment of the MLR rebate by MCO will cause the MCO's risk-based capital to fall below levels required by the West Virginia Offices of the Insurance Commissioner, the MCO's responsible official must notify the Department in writing as soon as administratively possible and prior to making any MLR rebate payments to the Department.

PERFORMANCE MEASURES

(Each goal should be linked to one or more performance measures)

Measure	Goal Linked	Source

DESCRIPTION OF MONITORING ACTIVITIES

EVALUATION OF EFFECTIVENESS OF PREVIOUS CONTRACT YEAR

(Please provide performance reports)

SUMMARY

(Please describe lessons learned and any implemented changes)

APPENDIX I: SOCIALLY NECESSARY CRIMES AND WAIVERS PROTOCOL

Effective March 1, 2010

1. Employees who work for Providers of Socially Necessary Services must possess no child or adult maltreatment substantiations and must have no criminal convictions in order to be eligible for employment unless a waiver is granted. Waivers may be requested when any of the following conditions apply:
   a. Any convictions of crimes of deceit or dishonestly are at least ten (10) years old (i.e., forgery, bad checks);
   b. DUI convictions must be at least five (5) years old;
   c. Any convictions involving reckless, erratic, and/or dangerous driving behaviors must be at least two years old;
   d. Any misdemeanor drug convictions must be at least ten (10 years old;
   e. An applicant must not be approved, employed, nor utilized if convicted of two (2) or more misdemeanors unless the convictions are far enough in the past to indicate that behavior change has occurred and a waiver is requested and approved (1-5 years, depending on the nature of the crimes);

2. Any convictions that are not eligible for waiver under the Department's current CIB policy will not be considered for waiver under the SNS policy. Those crimes are as follows:
   a. Abduction;
   b. Any violent felony crime including but not limited to rape, sexual assault, homicide, malicious wounding, unlawful wounding, felonious domestic assault, or battery;
   c. Child/adult abuse or neglect;
   d. Crimes which involve the exploitation of a child or an incapacitated adult;
   e. Misdemeanor domestic battery or domestic assault;
   f. Felony arson;
   g. Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
   h. Felony drug related offenses within the last ten (10) years;
   i. Felony DUI within the last ten (10) years;
   j. Hate crimes;
   k. Kidnapping;
   l. Murder/homicide;
   m. Neglect or abuse by a caregiver;
   n. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct;
   o. Purchase or sale of a child;
   p. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;

3. There is no forgiveness for CPS/APS maltreatment substantiations.

APPENDIX J: STAKEHOLDER FOCUS GROUP QUESTIONS TEMPLATE

1. Is your current agency/family committed to providing health and educational materials that appeal to various social, cultural and special needs groups?

2. Are intake forms or materials available in different languages?

3. Does your provider offer assistance for those with disabilities? For example: large print, sign language, assistive technology.

4. Does the agency have trained interpreters readily available for various languages, including sign language?

5. Do the agency/families have established connections with various communities, cultural, ethnic and religious groups to help better serve diverse groups?

6. In the past six (6) months has this agency sponsored at least one activity that has helped improve communication and teamwork between residents of different cultural, language and ethnic groups?

7. Do you have the opportunity to attend racial group holidays or functions within diverse communities? What was it?

8. Are you provided linkages with advocates for diverse communities who can give you reliable information regarding community opinions about diverse and important issues?

9. Do you have access to religious services in which you affiliate?

10. Does your care provider (Family) alter your programming or care based on your values or culture?

11. Do you feel your services are tailored to your needs?

12. Are visitations arranged in situations you and your family are comfortable- physically and emotionally?

13. Are you allowed visits with siblings, extended family, kin or your friends you want to keep in touch with from home?

14. Are you able to contact family and friends besides visitation, phone calls and letters? Do you have access to e-mail, skype, face time, texting, twitter, Facebook, Instagram, snapchat?

15. If you are celebrating a special occasion or holiday do you have input in the planning? Are your family traditions considered, foods your family likes, ways to decorate?

16. Do you have access to personal care items or services that match your needs? (such as Haircuts)

17. Do you feel you get to express your personal style in clothing and appearance?

APPENDIX K: PROVIDER NETWORK STANDARDS

This appendix summarizes the network standards and methodology for the MCO serving enrollees under this Contract. These standards represent experience in West Virginia and current practices, recent utilization, patterns of care, and provider network standards used by other state Medicaid programs. The intent of setting these standards is to ensure members have adequate access to all covered services.

General Network Requirements

In accordance with 42 CFR §438.68(b),the MCO must establish and maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services available to the populations served in a timely manner. The information provided represents the minimum standards for the MCO's provider network. However, the MCO must ensure access to all services included in the MCO benefits package, even where a standard for the specialty type has not been defined.

As described below, the provider network standards for West Virginia's MCO program include provider-to-enrollee ratios and travel time and distance. The provider-to-enrollee ratios ensure that MCO provider networks have adequate capacity, while the travel time and distance standards establish choice and geographic accessibility of providers. Together, these standards ensure medical services are accessible throughout the State.

In order to meet access requirements, the MCO must meet the defined provider-to-enrollee ratios and time and distance standards in every county. In calculating provider-to-enrollee ratios, the MCO may only count *unique providers* located within the county. For the time and travel standard, the MCO may count *all provider locations* within the county or within the appropriate travel time from the county border. Travel time and distance standards are measured from the enrollee's residence to the provider's location. Network standards are consistent across the counties.

Medical Provider Access Standards

Provider-to-Enrollee Ratios

For all adult and pediatric populations served, the MCO must contract with a sufficient number of active providers in each county to meet the following standards.

Provider Type	Adult Standard	Pediatric Standard
PCP	One **(1) provider** for every five hundred **(500) enrollees** per county	One **(1) provider** for every two hundred fifty **(250) enrollees** per county
OB/GYN or certified nurse midwife	One **(1) provider** for every one thousand **(1,000) enrollees** per county	

Medical Provider Network Time and Travel Distance

The MCO must contract with a sufficient number of active providers accepting new patients to meet the following standards for all adult and pediatric populations. For review purposes, medical providers are grouped into the following categories: PCP, OB/GYNs, frequently-used

Provider Category	Provider Type	Adult Standard	Pediatric Standard
PCP	PCP	Two (2) providers within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) providers within twenty (20) **miles** or thirty (30) **minutes** travel time
OB/GYN	OB/GYN or certified nurse midwife	Two (2) providers within twenty-five (25) **miles** or thirty (30) **minutes** travel time	
Frequently-Used Specialist	Allergy	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Audiology	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Cardiology	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Dermatology	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	General Surgery	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Gastroenterology	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Neurology	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Occupational Therapy	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Oncology	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Ophthalmology	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Orthopedics	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Orthopedic Surgeon	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Otolaryngology / Otorhinolaryngology	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Physical Therapy	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	Two (2) provider within twenty (20) **miles** or thirty (30) **minutes** travel time

Provider Category	Provider Type	Adult Standard	Pediatric Standard
	Podiatry	One (1) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	One (1) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Radiology	One (1) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	One (1) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Thoracic Surgery	One (1) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	One (1) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
	Urology	One (1) provider within twenty (20) **miles** or thirty (30) **minutes** travel time	One (1) provider within twenty (20) **miles** or thirty (30) **minutes** travel time
Hospital	Basic Hospital Services	**Urban:** One (1) hospital within thirty (30) **miles** or forty-five (45) **minutes** travel time **Rural:** One (1) hospital within sixty (60) **miles** or ninety (90) **minutes** travel time	**Urban:** One (1) hospital within thirty (30) **miles** or forty-five (45) **minutes** travel time **Rural:** One (1) hospital within sixty (60) **miles** or ninety (90) **minutes** travel time
	Tertiary Hospital Services[18]	**Urban:** One (1) hospital within thirty (30) **miles** or forty-five (45) **minutes** travel time **Rural:** One (1) hospital within sixty (60) **miles** or ninety (90) **minutes** travel time	**Urban:** One (1) hospital within thirty (30) **miles** or forty-five (45) **minutes** travel time **Rural:** One (1) hospital within sixty (60) **miles** or ninety (90) **minutes** travel time

[18] Tertiary hospital services include (1) acute care services to pediatric patients in medical and surgical units; (2) obstetrics services; and (3) a neo-natal intensive care unit.

Hospital Name
St Joseph's Buckhannon (NPIs may include 1649503418, 1376884213, 1124005061)
St Mary's Medical Center (NPIs may include 1164492195)
Stonewall Jackson (NPIs may include 1114195435, 1477559433)
Summersville Memorial (NPIs may include 1104813740, 1043778319)
Thomas Memorial (NPIs may include 1316925506)
Webster County (NPIs may include 1417621723, 1609535830, 1114691417, 1407930639, 1134203367, 1699778704, 1073690004, 1043287030, 1194804252, 1588748719, 1114003456, 1679241152, 1568439552)
Weirton Medical Center (NPIs may include 1619921947, 1770921603)
Welch Community (NPIs may include 1134158900)
Wetzel County (NPIs may include 1376175240, 1730396482, 1194753145, 1326115221)
Wheeling Hospital (NPIs may include 1104821305)
Williamson Memorial Hospital
WVU Hospitals (NPIs may include See rows 43 - 52; MSLC_Tertiary_Hospital_IDs 38 - 46)
WVU Medicine Berkeley Medical Center (NPIs may include 1851539381, 1750475281, 1487745436)
WVU Medicine Jefferson Medical Center (NPIs may include 1982704961, 1891722377)
WVU Medicine United Hospital Center (NPIs may include 1184606600)

Pediatric Dental Network Access Standards

The MCO must contract with a sufficient number of active dental providers accepting new patients and meet the following standards for all pediatric populations. For review purposes, dental providers are grouped as dentists or dental specialists. The requirements for each specialty group are outlined below.

Provider Category	Provider Type	Adult Standard	Pediatric Standard
SUD Facility	Residential SUD provider	One (1) provider within forty-five **(45) miles** or sixty **(60) minutes** travel time	One (1) provider within forty-five **(45) miles** or sixty **(60) minutes** travel time

Provider Category and Provider Type: BH Facility - Behavioral Health Clinics

Adult and Pediatric Standard	
Contract with identified list:	NPIs may include:
Appalachian Community Health Center	1174681365, 1457629602, 1639237837, 1720146921, 1730457987, 1811055015, 1073703609, 1346430352, 1083804611
EastRidge Health Systems, Inc.	1073756920, 1093135584, 1275701674, 1427197748, 1447511209, 1528488012, 1811317308, 1861812356, 1982974416
FMRS Health Systems, Inc.	1144437880, 1629294384, 1740406404, 1881733616, 1972871358
Healthways, Inc.	1104077882, 1124282785, 1255545117, 1366656225, 1366826448, 1558425975, 1689837072, 1790160976, 1841569084
Logan-Mingo Area Mental Health, Inc.	1861023699
Northwood Health Systems, Inc.	1417173444, 1144408691, 1205052255, 1225169113, 1396961348, 1437337987, 1457538886, 1538438403, 1629294673, 1780862235, 1881872331
Potomac Highlands Mental Health Guild, Inc.	1114654548
Prestera Center for Mental Health Services	1922019074, 1043436918, 1356336903, 1427278480, 1740443530, 1942563721, 1962772897, 1659382703
Seneca Health Services, Inc.	1407028418, 1992186191, 1154532513, 1245441609, 1518953652, 1568601979, 1790924983, 1972984490
Southern Highlands	1740234673
United Summit Center, Inc.	1003185687, 1689886558, 1528270493, 1891907788
Valley Comprehensive Community Mental Health Center, Inc.	1427477934, 1154740660, 1255750774
Westbrook Health Services, Inc.	1568889525, 1952357568, 1710235379, 1407325640, 1023249620

The MCO must submit supporting data tables with each map. The supporting data tables must include, at a minimum, the name of county, the number of eligible enrollees in the county, the provider type, the number of providers of that type in the county, the number of enrollees with access to the provider type, the number of enrollees without access to provider type, the percentage of enrollees with access to the provider type, the percentage of enrollees without access to provider type, and the average distance to available providers.

The tables with the supporting data must follow each individual geographic data map. BMS will provide sample PDF and Excel formats for the geo maps and supporting data. The MCO must provide data for all provider types in both PDF and Excel formats.

The geographic data maps in PDF format and supporting tables in PDF and Excel by county for each provider type for which there is a defined time or distance standard must be submitted to the Department annually, by October 31st.

Submission of Provider Network File

The MCO must submit to the Department annually by October 31st an Excel file listing all providers and facilities in the MCO's network for the Medicaid line of business only. Prior to submission, the Department will provide an Excel file template for the requested data. The files must contain the following information for ***all*** providers and facilities contracting with the MCO:

1. Provider names listed in separate columns for last name, first name, middle initial, and degree
2. Provider specialty
3. Provider office names
4. Provider type (e.g., physician, physician assistant (PA), nurse midwife, therapist, FQHC, psychologist, dentist)
5. Provider addresses, including the county in which the provider office is located (list all provider locations, including out-of-state)
6. Indicator for providers that are not accepting new patients
7. Other provider restrictions, listed in separate columns by type of restriction (i.e., age restrictions, gender restrictions, or any other restrictions)
8. Indicator for whether the physician acts as a PCP for physicians with primary care specialties (e.g., family practice, general practice, internal medicine, internal medicine, pediatrics)
9. NPI and tax ID number, if available

The MCO may submit separate files for medical, dental, behavioral health, if preferred.
Any network changes must be reported quarterly (forty-five (45) calendar days after end of the quarter) to the Department by specialty using the same format.

Submission of Ratio Worksheet

The MCO must complete the provider-to-enrollee ratio worksheet for PCPs and OB/GYNs, using the Department-provided template. The Department-provided template contains instructions on which fields the MCO must populate. The MCO must submit the ratio worksheet to the Department annually by October 31st.

WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES

STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Cynthia A. Persily, Ph.D.
Cabinet Secretary

Cynthia Beane
Commissioner

DATE: August 22, 2024

TO: Crystal Hustead
Senior Buyer
State of West Virginia Purchasing Division

FROM: Althea Greenhowe Althea Greenhowe
Procurement Specialist, Senior
Office of Shared Administration

RE: PF1052601, CMA BMS23*03-Change Order 2
Dept 0511

The West Virginia Bureau for Medical Services (BMS) respectfully requests the approval of the above-referenced CMA change order two (2). This change order is issued to renew the original contract according to all terms, conditions, prices and specifications contained in the original contract including all authorized change orders.

This will be optional renewal year one (1) of three (3) one (1)- year renewals. The service period will be 07/01/2024-06/30/2025. The estimated cost is $150,000,000.00.

This change order is being submitted currently due to the delay in receiving associated order documentation and internal approvals.

Please feel free to contact me if additional documentation or details are needed. I can be reached at 304-352-4319 or lakendra.burdette@wv.gov. Thank you for your time and consideration in this matter.

Backdate
apd

COMPLIANCE VERIFICATION CHECKLIST
FOR REQUISITION SUBMISSION

Purchasing Division Use:	
Buyer: Crystal Huslead Date: 9/25/24	Agency: BMS
Solicitation No. CMA BMS23*03	Procurement Officer Submitting Requisition: Althea Greenhowe
	Requisition No. CMA 0511 BMS23*3
	PF No.: 1052601

This checklist **MUST** be completed by a state agency's designated procurement officer and submitted with the Purchase Requisition to the Purchasing Division. The purpose of the checklist is to verify that an agency procurement officer has obtained and included required documentation necessary for the Purchasing Division to process the requisition without future processing disruptions. At the agency's preference, the agency **MUST** either submit the checklist by attaching it to the requisition's Header **OR** by placing it in the requisition's Procurement Folder.

FOR ALL SOLICITATION TYPES:

	Compliance Check Type	Required	Provided, if Required	Not Required	Purch. Div. Confirmation
1	Specifications and Pricing Page included	☑	☐	☐	☐
2	Use of correct specification template	☑	☐	☐	☐
3	Use of correct requisition type [CRQS → CCT or CPO] or [CRQM → CMA]	☑	☐	☐	☐
4	Use of most current terms and conditions (www.state.wv.us/admin/purchase/TCP.pdf)	☑	☐	☐	☐
5	Maximum budgeted amount in *wv*OASIS	☑	☐	☐	☐
6	Suggested vendors in *wv*OASIS	☑	☐	☐	☐
7	Capitol Building Commission pre-approval	☐	☐	☐	☐
8	Financing (Governor's Office) pre-approval	☐	☐	☐	☐
9	Fleet Management Division pre-approval	☐	☐	☐	☐

	Compliance Check Type	Required	Provided, if Required	Not Required	Purch. Div. Confirmation
10	Insurance requirements				
	Commercial General Liability	☐	☐	☐	☐
	Automobile Liability	☐	☐	☐	☐
	Workers' Compensation/Employer's Liability	☐	☐	☐	☐
	Cyber Liability	☐	☐	☐	☐
	Builder's Risk/Installation Floater	☐	☐	☐	☐
	Professional Liability	☐	☐	☐	☐
	Other (specify)	☐	☐	☐	☐
11	Office of Technology CIO pre-approval	☐	☐	☐	☐
12	Treasurer's Office (banking) pre-approval	☐	☐	☐	☐

FOR CHANGE ORDERS/RENEWALS:

1	Two-party agreement	☑	☑	☐	☑
2	Standard change order language	☑	☑	☐	☑
3	Office of Technology CIO approval	☑	☑	☐	☑
4	Justification for price increases/backdating/other	☑	☑	☐	☐
5	Bond Rider (Construction)	☐	☐	☑	☐
6	Secretary of State Verification	☑	☑	☐	☑
7	State debarment verification	☑	☑	☐	☑
8	Federal debarment verification	☑	☑	☐	☑

**The items pre-checked are required before a Purchase Requisition may be submitted to the Purchasing Division. Failure to complete and verify this documentation may result in rejection of the requisition back to the agency. It is up to the agency procurement officer to determine if pre-approvals, insurance, or other documentation is needed for the purchase. The referenced information below may be used to make this determination.*

For Purchasing Division Use Only:

I have reviewed the requisition identified above and find that it is sufficient to advertise publicly to the vendor community. My review does not preclude the possibility that the vendor community, or some other entity, will identify an area of concern; however, should such issues or concerns arise, they will be reviewed and addressed as may be appropriate.

Signature: Crystal Hustead

STATE OF WEST VIRGINIA
DEPARTMENT OF ADMINISTRATION
OFFICE OF TECHNOLOGY
State Capitol
Charleston, West Virginia 25305

John K. McHugh
Interim Cabinet
Secretary

Heather D. Abbott
Chief Information Officer

TO: **Curtis Burress, Procurement Associate**
Department of Human Services

FROM: **Heather D. Abbott, Chief Information Officer**
Office of Technology

SUBJECT: **INFORMATION TECHNOLOGY PROCUREMENT**
HR005714 IS&C NUMBER: 2025-2139

DATE: **September 16, 2024**

West Virginia Code §5A-6-4(a) permits the Chief Information Officer to review and approve technology purchases for suitability to ensure such purchases comport with the State of West Virginia's overall strategic information technology goals.

West Virginia Code §5A-6-4c requires the Chief Information Officer to review and approve "technology projects."

West Virginia Code §5A-6-5 requires that "any state spending unit that pursues an information technology purchase that does not meet the definition of a 'technology project' and that is required to submit a request for proposal to the State Purchasing Division prior to purchasing goods or services shall obtain the approval of the Chief Information Officer, in writing, of any proposed purchase of goods or services related to its information technology and telecommunication systems.

After conducting a review of your request for CMA BMS23*03-Change Order 2, the Office of Technology has determined:

X That your request is approved.

That your request is not subject to the review and approval provisions contained in Chapter 5A, Article 6 of the Code, therefore, it does not need approval by the Office of Technology.

This memorandum constitutes this office's official review and a copy should be attached to your purchase order and any other correspondence related to this request. If you have questions, or need additional information, please contact Consulting Services at Consulting.Services@wv.gov.

Any Words ⓘ

All Words ⓘ

Exact Phrase ⓘ

e.g. 123456789, Smith Corp

"COVENTRY HEALTH CARE OF WEST VIRGINIA INC" ×

Classification

Excluded Individual

Excluded Entity

Federal Organizations

Exclusion Type

- ✓ Ineligible (Proceedings Pending)
- ✓ Ineligible (Proceedings Complete)
- ✓ Prohibition/Restriction
- ✓ Voluntary Exclusion

Exclusion Program

Location

Dates

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Business Organization Detail

NOTICE: The West Virginia Secretary of State's Office makes every reasonable effort to ensure the accuracy of information. However, we make no representation or warranty as to the correctness or completeness of the information. If information is missing from this page, it is not in the The West Virginia Secretary of State's database.

COVENTRY HEALTH CARE OF WEST VIRGINIA, INC.

Organization Information							
Org Type	Effective Date	Established Date	Filing Date	Charter	Class	Sec Type	Termination Date	Termination Reason
C | Corporation	8/16/1991		8/16/1991	Domestic	Profit			

Organization Information			
Business Purpose	6241 - Health Care and Social Assistance - Social Assistance - Individual and Family Services (child, youth, elderly, disabled)	Capital Stock	1000000.0000
Charter County		Control Number	0
Charter State	WV	Excess Acres	0
At Will Term		Member Managed	
At Will Term Years		Par Value	1000.000000
Authorized Shares	1000	Young Entrepreneur	Not Specified

Addresses

Type	Address
Local Office Address	500 VIRGINIA STREET EAST SUITE 400 CHARLESTON, WV, 25301
Mailing Address	151 FARMINGTON AVENUE RW61 HARTFORD, CT, 06156 USA
Notice of Process Address	C T CORPORATION SYSTEM 5098 WASHINGTON ST W STE 407 CHARLESTON, WV, 253131561
Principal Office Address	500 VIRGINIA STREET EAST SUITE 400 CHARLESTON, WV, 25301 USA
Type	Address

Officers

Type	Name/Address
	SEE ATTACHED LIST
Director	BRYAN S. NAZWORTH 500 VIRGINIA STREET E. SUITE 400 CHARLESTON, WV, 25301
Director	TODD R. WHITE 500 VIRGINIA STREET E. SUITE 400 CHARLESTON, WV, 25301
President	TODD R. WHITE 500 VIRGINIA STREET E. SUITE 400 CHARLESTON, WV, 25301
Secretary	AARON J IGDALSKY 500 VIRGINIA STREET E. SUITE 400 CHARLESTON, WV, 25301
Treasurer	TRACY L. SMITH 500 VIRGINIA STREET E. SUITE 400 CHARLESTON, WV, 25301
Vice-President	AARON J. IGDALSKY 500 VIRGINIA STREET E. SUITE 400 CHARLESTON, WV, 25301
Type	Name/Address

DBA

DBA Name	Description	Effective Date	Termination Date
AETNA BETTER HEALTH OF WEST VIRGINIA	TRADENAME	12/11/2015	
CARELINK	TRADENAME	5/8/1996	
CARELINK HEALTH LINE	TRADENAME	5/8/1996	
CARELINK HEALTH PLANS	TRADENAME	5/8/1996	
COVENTRY HEALTH CARE	TRADENAME	11/19/2007	
DBA Name	**Description**	**Effective Date**	**Termination Date**

Name Changes

Date	Old Name
9/4/2012	CARELINK HEALTH PLANS, INC.
Date	**Old Name**

Mergers

Merger Date	Merged	Merged State	Survived	Survived State
2/10/2000	PRIMEONE, INC.	WV	CARELINK HEALTH PLANS, INC.	WV
Merger Date	**Merged**	**Merged State**	**Survived**	**Survived State**

Date	Amendment
4/10/2019	AMENDED & RESTATED ARTICLES OF INCORPORATION
9/4/2012	NAME CHANGE: FROM CARELINK HEALTH PLANS, INC.
2/16/2000	CHANGE -AMENDMENT & RESTATED ART FILED; UPDATED THE AGENT
2/16/2000	DECREASE IN SHARES FROM 400,000 SHARES AT NO PAR VALUE TO 1,000 SHARES AT $1,000.00 PAR WHICH MAKES THE AUTH CAP $1,000,000.00
2/10/2000	MERGER: MERGING PRIMEONE, INC., A QUALIFIED WV CORPORATION WITH AND INTO CARELINK HEALTH PLANS, INC. A QUALIFIED WV CORPORATION, THE SURVIVOR
10/1/1999	MERGER; MERGING COVENTRY HEALTH PLAN OF WEST VIRGINIA, INC., A QUAL WV CORP WITH & INTO CARELINK HEALTH PLANS, INC., A QUAL WV CORP, THE SURVIVOR.
9/16/1999	CHANGE - REDUCTION IN STATED CAPITAL
5/19/1999	INCREASE IN SHARES FROM 200,000 AT NO PAR VALUE TO 400,000 AT

	NO PAR VALUE.
9/5/1997	CHANGE OF NAME FROM CHARLESTON AREA HEALTH PLAN, INC. TO CARELINK HEALTH PLANS, INC.
10/5/1995	CHANGE IN PAR VALUE FROM 200,000 SHARES AT $100.00 WITH AUTH CAP. BEING $20,000,000.00 TO 200,000 SHARES AT NO PAR VALUE; ALSO UPDATED PRES.
8/11/1994	CHANGE - RESTATED ART. OF INC.-INCREASE IN AUTH. CAP. STK FROM $2,000.00 WITH 200,000 SHARES AT $0.01 PAR TO $20,000,000.00 AUTH. CAP WITH 200,000 SHARES AT $100.00 PAR VALUE.
5/27/1994	CHANGE-RESTATED ART OF INC-INCREASE IN AUTH CAP STKFROM $100.00 & 10,000 SHARES AT $.01 PAR VALUE TO $2,000 AUTH. CAP. WITH 200,000 SHARES AT $.01 PAR VALUE & ALSO CHANGED PRIN OFF,AGENT & ADDED DIR. & OFF.
3/29/1994	CHANGE IN PRIN. OFF., AGENTS ADD. AND UPDATED DIR.
Date	**Amendment**

Annual Reports

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For more information, please contact the Secretary of State's Office at 304-558-8000.

Tuesday, September 24, 2024 — 8:17 AM