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: 08-04-2025

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 5
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 04 To Renew Contract
Effective Start Date:	2023-07-01
Effective End Date:	2026-06-30

VENDOR

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

Charleston WV 25301-2135
US

Vendor Contact Phone: 304-348-2041 **Extension:**

Discount Details:

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

DEPARTMENT CONTACT

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

2026
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

CR 8-7-25

Total Order Amount: Open End

Purchasing Division's File Copy

CH 8/5/25

PURCHASING DIVISION AUTHORIZATION
DATE: 8/6/25
ELECTRONIC SIGNATURE ON FILE

ATTORNEY GENERAL APPROVAL AS TO FORM
DATE: 8/18/2025
ELECTRONIC SIGNATURE ON FILE

ENCUMBRANCE CERTIFICATION
DATE: 8-18-25
ELECTRONIC SIGNATURE ON FILE

Extended Description:
Change Order

Change Order No. 4 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.

Effective date of renewal 07/01/2025 through 06/30/2026.

Renewal Years Remaining: 1

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

Line	Commodity Code	Manufacturer	Model No	Unit	Unit Price
3	84131602				0.000000
	Service From	**Service To**		**Service Contract Amount**	
	2025-07-01	2026-06-30		1127161.08	

Commodity Line Description: Vendor's Bid Amount for Administrative Services (SNS) Year 3

Extended Description:
Vendor's Bid Amount for Administrative Services (SNS) Year 3

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 18, 2025

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

RE: SFY2026 Purchase of Service Provider Agreement for Mountain Health Promise
CMA BMS23*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 2026 Purchase of Service Provider Agreement Between the State of West Virginia Department of Human Services 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

WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES

STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Alex J.Mayer
Cabinet Secretary

Cynthia Beane, MSW, LCSW
Commissioner

DATE: July 10, 2025

TO: Crystal Hustead
Senior Buyer
State of West Virginia Purchasing Division

FROM: Althea Greenhowe
Procurement Specialist, Senior
Office of Shared Administration

RE: PF1052601, CMA BMS23*03-Change Order 4
Dept 0511

The West Virginia Bureau for Medical Services (BMS) respectfully requests the approval of the above-referenced CMA change order four (4). 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 two (2) of three (3) one (1)- year renewals. The service period will be 07/01/2025-06/30/2026. 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 304-352-3924 or althea.m.greenhowe@wv.gov. Thank you for your time and consideration in this matter.

STATE FISCAL YEAR 2026

MODEL PURCHASE OF SERVICE PROVIDER AGREEMENT FOR MOUNTAIN HEALTH PROMISE

BETWEEN

STATE OF WEST VIRGINIA

DEPARTMENT OF HUMAN SERVICES

BUREAU FOR MEDICAL SERVICES

AND

Aetna Better Health of West Virginia

STATE OF WEST VIRGINIA

DEPARTMENT OF HUMAN SERVICES

PURCHASE OF SERVICE PROVIDER AGREEMENT

Table of Contents

ARTICLE I: STANDARD WEST VIRGINIA TERMS 8

1. GENERAL TERMS AND CONDITIONS 9

2. CONTRACT TERM 9

3. ENTIRE AGREEMENT 10

4. CONTRACT ADMINISTRATION 10

5. NOTICES 10

ARTICLE II: GENERAL CONTRACT TERMS FOR MANAGED CARE ORGANIZATIONS 11

1. DEFINITIONS 11

2. DELEGATIONS OF AUTHORITY 29

3. FUNCTIONS AND DUTIES OF THE MANAGED CARE ORGANIZATION 29

4. FUNCTIONS AND DUTIES OF THE STATE 29

4.1 Eligibility Determination 29

4.2 Enrollment 29

4.3 Enrollee Assignment 29

4.4 Voluntary and Involuntary Disenrollment 29

4.5 Capitation Payments to Managed Care Organization 30

4.6 Federal Disallowance 31

4.7 Enrollee Eligibility Capitation Adjustments 31

4.8 Information 32

4.9 Ongoing Managed Care Organization Monitoring 32

4.10 Utilization Review and Control 32

4.11 Force Majeure 33

4.12 Time Is of the Essence 33

4.13 MCO Response Time Frames 33

5. DECLARATIONS AND MISCELLANEOUS PROVISIONS 33

5.1 Competition Not Restricted 33

5.2 Binding Authority 34

5.3 Nonsegregated Facilities *34*
5.4 Offer of Gratuities *34*
5.5 Employment/Affirmative Action Clause *34*
5.6 Hold Harmless *34*
5.7 Confidentiality *35*
5.8 Independent Capacity *35*
5.9 Contract Liaison *35*
5.10 Key Staff Positions *36*
5.11 Location of Operations *42*
5.12 Communication with the Department *43*
5.13 Waivers *43*
5.14 Compliance with Applicable Laws, Rules, And Policies *43*
5.15 Non-discrimination *45*
5.16 Federal Requirements and Assurances *45*
5.17 Lobbying *46*
5.18 Disclosure of Interlocking Relationships *46*
5.19 Department's Data Files *46*
5.20 Changes Due to a Section 1915(b) Freedom of Choice, 1915(c) Home and Community-Based, or 1115 Demonstration Waiver *47*
5.21 Contracting Conflict of Interest Safeguards *47*
5.22 Prohibition Against Performance Outside the United States *47*
5.23 Freedom of Information *48*
6. CONTRACT REMEDIES AND DISPUTES **48**
6.1 MCO Performance *48*
6.2 Corrective Action Plan (CAP) *49*
6.3 Conditions Endangering Performance *50*
6.4 Failure to Meet Contract Requirements *51*
6.5 Temporary Management *53*
6.6 Suspension of New Enrollment *53*
6.7 Payment Suspension *53*
6.8 Dispute Resolution *54*
6.9 Termination For Default *55*
6.10 Termination for Convenience *56*
6.11 Termination Due to Change in Law, Interpretation of Law, or Binding Court Decision *56*
6.12 Termination for Managed Care Organization Bankruptcy *57*
6.13 Termination for Unavailability of Funds *57*

6.14 Termination Obligations of Contracting Parties 57
6.15 MCO Operations Transition 58
6.16 Cooperation with Other Contractors and Prospective Contractors 59
6.17 Waiver of Default or Breach 59
6.18 Severability 59
6.19 Modification of the Contract in the Event of Remedies 60
7. POST-AWARD READINESS REVIEW **60**
8. OTHER REQUIREMENTS **60**
8.1 Inspection of Facilities 60
8.2 MCO Requirements Related to Information Systems and Other Technology 61
8.3 Maintenance and Examination of Records 62
8.4 Audit Accounting and Retention of Records 63
8.5 Subcontracts 65
ARTICLE III: STATEMENT OF WORK **70**
1. COVERED POPULATIONS **70**
2. COVERED SERVICES **70**
2.1 Covered MCO Services 70
2.2 Additional Requirements/Provisions for Certain Services 72
2.3 Medicaid Benefits Covered but Excluded from Capitation that Require Coordination 82
2.4 Non-covered Services 83
2.5 Other Requirements Pertaining to Covered Services 85
2.6 Requirements Pertaining to Medicaid Managed Care Programs 86
3. PROVIDER NETWORK **86**
3.1 General Requirements 86
3.2 Primary Care Providers (PCPs) 96
3.3 Specialty Care Providers, Hospitals and Other Providers 99
3.4 Publicly Supported Providers 100
3.5 Mainstreaming 103
3.6 Provider Services 103
3.7 Provider Reimbursement 109
3.8 Prohibitions on Inappropriate Provider Incentives 114
4. ENROLLMENT & ENROLLEE SERVICES **115**
4.1 Marketing 115
4.2 Enrollment 116
4.3 Enrollee Services Department 119

4.4 Materials *120*
4.5 Education *127*
4.6 Enrollee Rights *129*
4.7 Enabling Services *131*
4.8 Grievances and Appeals *132*
4.9 Cost-Sharing Obligations *139*
4.10 Value-Added Services *140*
4.11 Population Health *142*
5. MEDICAID ADMINISTRATOR/CONTRACT LIAISON FUNCTIONS **146**
6. HEALTH CARE MANAGEMENT **147**
6.1 Second Opinions *147*
6.2 Out-of-Network Services *147*
6.3 Continuity and Coordination of Care *147*
6.4 Service Authorization (Prior Authorization) *160*
6.5 Rural Option *163*
6.6 Utilization Management *163*
6.7 Practice Guidelines and New Medical Technology *164*
6.8 Enrollee Medical Records and Communication of Clinical Information *164*
6.9 Confidentiality *167*
6.10 Reporting Requirements *168*
7. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM **177**
7.1 Required Levels of Performance *178*
7.2 Performance Improvement Projects (PIPs) *178*
7.3 Systemic Problems *180*
7.4 Health Information System *180*
7.5 Administration of the QAPI Program *181*
7.6 MCO NCQA Accreditation *183*
7.7 Performance Profiling *183*
8. FINANCIAL REQUIREMENTS & PAYMENT PROVISIONS **183**
8.1 Solvency Requirements *183*
8.2 Capitation Payments to MCOs *184*
8.3 Third Party Liability (TPL) *186*
8.4 Special Payment Arrangements *188*
8.5 Enrollee Liability *191*
8.6 Managed Care Premium Tax *191*

9. FRAUD, WASTE, AND ABUSE REQUIREMENTS 192
9.1 Fraud, Waste, and Abuse Guidelines 192
9.2 Credible Allegation of Fraud 197
9.3 Treatment of Overpayments 198
10. DENTAL SERVICES 201
10.1 Children's Dental Services Administration 201
10.2 MHP Adult Dental Services Administration and Covered Services 202
10.3 Dental Director 203
10.4 Oral Health Fluoride Varnish Program 203
10.5 Coordination of Care 203
10.6 Continuity of Care for MCO Orthodontic Services 203
10.7 Continued Care for Active Orthodontia 203
11. BEHAVIORAL HEALTH SERVICES 204
11.1 MCO Behavioral Services Administration 204
11.2 Behavioral Health Director 205
11.3 Behavioral Health Covered Services 205
11.4 Coordination of Care 205
11.5 Adult Inpatient and Residential Care for Behavioral Health 205
11.6 Children's Inpatient Care for Behavioral Health 206
11.7 Court Ordered Services 206
11.8 Behavioral Health Provider Network 206
11.9 Behavioral Health Service Authorization 207
11.10 Substance Use Disorder (SUD) Services 207
11.11 Children with Serious Emotional Disorder (CSED) Waiver Services 211
11.12 Community-based Mobile Crisis Intervention Services 217
12. SOCIALLY NECESSARY SERVICES (SNS) 217
12.1 Contracting 217
12.2 Invoicing 217
12.3 Reporting 218
12.4 Retrospective Reviews 218
12.5 Authorization Requirements 218
12.6 Focus Groups 219
13. CHILDREN'S RESIDENTIAL TREATMENT FACILITIES/EMERGENCY SHELTERS 220
13.1 Provider Network 220
13.2 Qualified Residential Treatment Program (QRTP) 220

13.3 Focus Groups *222*
13.4 Provider Requirements *223*
14. PERSONAL CARE SERVICES **223**
15. COMMUNITY ENGAGEMENT REQUIREMENTS **223**
16. DELEGATION **223**
17. EMERGENCY AND DISASTER DECLARATION **223**
18. SIGNATURES **225**
APPENDIX A: DESCRIPTION OF MCO MEDICAL, BEHAVIORAL HEALTH, AND SOCIALLY NECESSARY SERVICES (SNS) COVERED AND EXCLUDED SERVICES **1**
APPENDIX B: OVERVIEW OF WEST VIRGINIA'S SFY 2023 PAYMENT METHODOLOGY AND CAPITATION RATES FOR MOUNTAIN HEALTH PROMISE **1**
APPENDIX C: MARKETING AND MEMBER MATERIALS POLICIES **1**
Legal Authorities *1*
MCO Marketing and Member Material Submissions *1*
General Marketing and Member Materials Policies *2*
Marketing Policies *3*
APPENDIX D: SUMMARY OF MCO REPORTING REQUIREMENTS **1**
APPENDIX E 1: DATA CERTIFICATION FORM **1**
APPENDIX E 2: DATA CERTIFICATION FOR MONTHLY AND WEEKLY ENCOUNTER DATA FILE SUBMISSION **2**
APPENDIX F: SERVICE LEVEL AGREEMENTS (SLA) AND LIQUIDATED DAMAGES MATRIX **1**
APPENDIX G: MEDICAL LOSS RATIO (MLR) REPORTING METHODOLOGY **1**
APPENDIX H: ALTERNATIVE PAYMENT MODEL (APM) REPORTING TEMPLATE **1**
APPENDIX I: SOCIALLY NECESSARY CRIMES AND WAIVERS PROTOCOL **1**
APPENDIX J: PROVIDER NETWORK STANDARDS **1**
GENERAL NETWORK REQUIREMENTS **1**
Medical Provider Access Standards *1*
Pediatric Dental Network Access Standards *6*
Behavioral Health Network Access Standards *6*
Essential Community Providers (ECPs) *8*
Network Adequacy for Additional Providers Types *8*

NETWORK SUBMISSION AND NETWORK ADEQUACY EVALUATION 8
Provider Network Submission 8
Provider Network Evaluation 9

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.

1. GENERAL TERMS AND CONDITIONS

Written MCO responses to a Request for Proposal, (including the Department's written responses to oral and written questions, appendices, amendments, and addenda) and/or to other formal requests by the Department for information and documents are hereby incorporated by reference as part of the Contract having the full force and effect as if specifically contained herein. In the event of a conflict in language between this Contract and other documents mentioned above, the following order of precedence will apply:

A. The terms of this Contract; and

B. MCO responses to the RFP.

In construing this Contract, whenever appropriate, the singular tense will also be deemed to mean the plural and vice-versa. Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and will not be construed to be a part of this Contract.

2. CONTRACT TERM

The term of this Contract is July 1, 2025 through June 30, 2026. The contract may be renewed, at the option of the Department, for two (2) additional successive one (1)-year periods. This Contract may be renewed upon the mutual written consent of the Department and the MCO, with written approval of the State of West Virginia, Department of Administration (DOA) Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). The Centers for Medicaid and Medicare Services (CMS) must review and approve this Contract or any amendments to thereof in accordance with 42 CFR §438.806.

Any request for renewal must be submitted to the State of West Virginia, DOA Purchasing Division thirty (30) days prior to the expiration date of the initial Contract term or appropriate renewal term. The Department will be responsible for submitting the request but the MCO assumes responsibility for submitting any documentation required for a renewal. A Contract renewal must be in accordance with the Contract Terms and Conditions of the original Contract. Renewal of this Contract is limited to successive one (1) year periods or multiple renewal periods of less than one (1) year, provided that the multiple renewal periods do not exceed thirty-six (36) months in total. Automatic renewal of this Contract is prohibited. Attorney General's approval may be required for the certain Contract Terms and Conditions proposed by the Department.

In the event the Department opts to renew the Contract, notice must be sent to the MCO thirty (30) calendar days prior to the end of the current Contract period. In the event a decision is made not to renew the Contract, notice will also be sent to the MCO thirty (30) calendar days prior to the end of the current Contract period.

Any modification to this Contract will be subject to the terms of the RFP with the capitation rates being adjusted to reflect the corresponding Fiscal Year.

Using actuarially sound standards, the Department will calculate capitation payments to the MCO on the annual basis for the State Fiscal Year (SFY) (plan year) time period (i.e., SFY25 begins July 1, 2025, and ends June 30, 2026).

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.

ARTICLE II: GENERAL CONTRACT TERMS FOR MANAGED CARE ORGANIZATIONS

1. DEFINITIONS

As used throughout this Contract, the following terms will have the meanings set forth below.

Abuse – provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Administrative Services Only (ASO) – a contract to administer benefits, such as claims processing, claims review, and network access.

Actuary – an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this Contract, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Administration for Children and Families (ACF) – a division within the federal Department of Health and Human Services (DHHS) responsible for promoting the economic and social well-being of families, children, individuals and communities.

Adoption Assistance – a social services program, under Title XX of the Social Security Act (SSA), that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local Department of Human Services or a child placing agency licensed by West Virginia.

Advance Directive – a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination – the MCO's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the MCO's reduction, suspension, or termination of a previously authorized service; the MCO's failure to provide services as required by the Contract; the MCO's failure to resolve grievances or appeals within the timeframes specified in this Contract; or the MCO's denial of a request by an enrollee who resides in a rural area with only one (1) MCO to receive out-of-network services; or the denial of an enrollee's request to dispute a financial liability, including copayments.

Adverse Childhood Experiences (ACEs) – stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related

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

West Virginia children. Bureau staff located in the county offices are responsible for the day-to-day delivery of services such as child and adult protective services, foster care, adoption, financial assistance, and food stamps.

Business Continuity Plan (BCP) – a plan that provides for a quick and smooth restoration of the MCO information system after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Capitation Payment – a payment the State makes periodically to the MCO on behalf of each beneficiary enrolled under this Contract and based on the actuarially sound capitation rate for the provision of covered services. Reimbursement for this contract will be designed using a braided funding stream, with Medicaid and BSS dollars being braided to develop a monthly capitation payment for holistic care. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

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.

Care Coordination – organizing patient care activities and sharing information among all the participants concerned with an enrollee's care to achieve safer and more effective care. Through organized care coordination, an enrollee's needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care.

Caregiver – the BSS-authorized caretaker for a child in Foster Care and may be a Foster Parent(s), relative(s), or staff of a twenty-four (24)-hour childcare facility.

Care Management –a team-based, person centered approach to effectively managing patients' medical, social and behavioral conditions. Care Management must include, at a minimum, the following:

- High-risk care management (e.g., high utilizers / high-cost beneficiaries);
- Care Needs Screening;
- Identification of enrollees in need of care management;
- Development of Care Plans (across priority populations);
- Development of comprehensive assessments (across priority populations);
- Transitional care management: management of enrollee needs during transitions of care (e.g., from hospital to home);
- Care Management for special populations (including pregnant women and children at-risk of physical, development, or socio-emotional delay);
- Chronic care management (e.g., management of multiple chronic conditions);
- Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
- Management of unmet health-related resource needs and high-risk social environments;
- Management of high-cost procedures (e.g., transplant, specialty drugs);
- Management of rare diseases (e.g., transplant, specialty drugs);

- 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

array of home- and community-based services that enable children who would otherwise require institutionalization to remain in their home and community.

Choice Counseling – the provision of information and services designed to assist enrollees in making managed care enrollment decisions; it includes answering questions and identifying factors to consider when choosing between managed care and fee-for-services (FFS). Choice counseling does not include making recommendations for or against enrollment into an MCO.

Cold-Call Marketing – any unsolicited personal contact by the MCO with a potential enrollee for the purpose of influencing the potential enrollee to enroll in that particular MCO. Cold Call Marketing includes, without limitation:

- Unsolicited personal contact with a potential enrollee outside of an enrollment event, such as door-to-door or telephone marketing.
- Any marketing activities at the enrollment events where participation is mandatory.
- Any other personal contact with a potential enrollee if the potential enrollee has not initiated the contact with the MCO.

Common Area (Marketing) – any area in a provider's facilities that is accessible to the general public. Common areas include, without limitation: reception areas, waiting rooms, hallways, etc.

Complaint – an expression of dissatisfaction made about an MCO decision or services received from the MCO when a grievance is filed; some complaints may be subject to appeal.

Consultant/Consultant Affiliates – any corporation, company, organization, or person or their affiliates retained by the Department to provide assistance in this project or any other project; not the MCO or Subcontractor.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – an enrollee survey program approved by the CAHPS Consortium which is overseen by the AHRQ. The CAHPS survey measures patient experience with health plans, providers, and health care facilities. This survey is conducted annually by the MCO and results are submitted to the External Quality Review Organization (EQRO).

Co-payment – a required payment made by an MCO enrollee for certain covered services or medical supplies in addition to a payment made by the MCO for that same covered service or medical supply.

Corrective Action – an improvement in a business process that may be required by the Department to correct or resolve a deficiency in the MCO's processes or actions.

Corrective Action Plan (CAP) – a detailed written plan that may be required by the Department to correct or resolve a deficiency in the MCO's processes or actions.

Cost-Sharing – copays that the MCO enrollee is billed at the time of service. Copays are determined by the Department based on the enrollee's family income. There are no premiums or deductibles under the West Virginia Medicaid program.

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

or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions.[1]

Electronic Health Record (EHR) – a digital version of a member's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

Emergency Care – includes inpatient and outpatient services needed immediately and provided by a qualified Medicaid provider for emergency medical, behavioral health, or dental conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing their health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; and that are needed to evaluate or stabilize an emergency medical condition. These include accidental injury and poison related problems and complaints that may be indicative of serious, life threatening medical problems, such as chest or abdominal pain, difficulty breathing or swallowing, or loss of consciousness. If the patient presents at the hospital emergency department and requests an examination, a nurse triage screening is always allowed. In the case of behavioral health services, emergency care means those clinical, rehabilitative, or supportive behavioral health services provided for behavioral health conditions or disorders for which a prudent layperson with an average knowledge of health and medicine, could reasonably expect to result in risk of danger to a person's self or others if not immediately treated. These include, but are not limited to, crisis stabilization treatment services.

Emergency Dental Condition – a dental or oral condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate services for relief of symptoms and stabilization of the condition; such conditions may include severe pain, hemorrhage, acute infection, traumatic injury to the teeth and surrounding tissue, or unusual swelling of the face or gums.

Emergency Medical Condition – conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the individual's health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Medical Transportation – ambulance services for an emergency medical condition.

Emergency Room Care – emergency services an enrollee receives in an emergency room.

Emergency Services – covered inpatient and outpatient services that are: given by a qualified provider; and are needed to evaluate or stabilize an emergency medical condition.

---

[1] Section 1905(r)(5) of the Social Security Act

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

the child's friends, or foster parents with whom the child has previously been placed. Relative of the child is an adult of at least twenty-one (21) years of age who is related to the child, by blood or marriage, within at least three (3) degrees.

Fiscal Agent – an entity performing administrative service functions, including provider payment, enrollee eligibility, and capitation payment functions, for the managed care program under a separate Contract with the Department.

Formal Grievance – a written expression of dissatisfaction with the conduct or action of an MCO other than those subject to appeal.

Foster Care – a twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the Title IV-E agency (WV BSS) has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Foster Parent – a substitute caregiver who assumes the daily caretaking responsibilities for children in BSS custody who have been placed in their home.

Fraud – an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Gender Affirmation Surgery – the surgical procedures by which the physical appearance and function of a person's primary and/or secondary sex characteristics are modified to establish greater congruence with their gender identity.

Gender Dysphoria – a distressed state arising from conflict between a person's gender identity and the sex the person has or was identified as having at birth in accordance with the definition and diagnostic criteria established by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Gift (Marketing) – any promotional item or incentive offered by an MCO to enrollees or potential enrollees.

Grievance – an expression of dissatisfaction, either orally or in writing, about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.

Grievance Process – the procedure for addressing an enrollee's grievances and complaints.

Grievance System – includes a grievance process, an appeals process, and access to the State's fair hearing system.

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 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 they want to address. The intent of the program is to partner with families so children grow up healthy, strong and ready to learn.

Hospice Services – services to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six (6) months or less to live. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization – care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care – care in a hospital that usually does not require an overnight stay.

Individualized Service Plan (ISP) – a plan developed by a Multidisciplinary Treatment Team (MDT) for a child who is involved in court proceedings either because of child abuse and neglect, status offense, or delinquency proceedings.

Information Security Plan – a written MCO compliance plan with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH).

In Lieu of Services (ILOS) –a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the State Plan in accordance with 42 C.F.R 438.3(e)(2). An ILOS can be used as an immediate or longer-term substitute for a covered service or setting under the State Plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State Plan.

Key Personnel – those staff as outlined within Article II, Section 5.10.

Liquidated Damages – reasonable estimates of the Department's projected financial loss and damage resulting from the MCO's non-performance.

Long-acting Reversible Contraceptives (LARC) – nonpermanent methods to prevent pregnancy lasting more than one cycle. LARC includes intrauterine devices (IUDs) and contraceptive injections and implants.

Managed Care Initiative – West Virginia's Medicaid managed care program, as described in the current state plan and federal waiver and amendments, and approved by CMS. This may include one or more MCOs and voluntary or mandatory enrollment options.

Managed Care Organization (MCO) – a Health Maintenance Organization (HMO) entity licensed to do business in the State of West Virginia, that has, or is seeking to qualify for, comprehensive risk contract, and that is:

1. A Federally qualified HMO that meets the advance directives requirements of 42 CFR §489, Subpart I; or
2. Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
    a. Makes the services it provides to all Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to fee-for-service (FFS) enrollees; and
    b. Meets the solvency standards of 42 CFR §438.116.

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.

Medically Necessary – refers to services or supplies for diagnosing, evaluating, treating, or preventing an injury, illness, condition, or disease, based on evidence-based clinical standards of

care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria.

For Medicaid covered medical or other health services to children under twenty-one (21) it refers to services which: a) are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability; b) are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; c) are consistent with the diagnosis of the conditions; d) are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

Mountain Health Trust (MHT) – the name of West Virginia's Medicaid mandatory managed care program for Temporary Assistance to Needy Families (TANF) and TANF-related children and adults who are eligible to participate in managed care.

Mountain Health Promise (MHP) – the name of West Virginia Medicaid's specialized managed care program for certain 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.

Multidisciplinary Team (MDT) – a team consisting of persons representing various disciplines associated with key components of the Foster Care assessment process. The MDT serves as the central point for decision making during the life of a case and develops the case plan. The purpose of the MDT meetings is to review the outcome and recommendations of the provider related to the assessment of the Foster Care enrollee and the enrollee's family.

National Committee for Quality Assurance (NCQA) – the independent organization that accredits MCOs, managed behavioral health organizations, and accredits and certifies Disease Management programs.

Network – doctors, hospitals, facilities, and other licensed health care professionals who contract with an MCO to give care to its enrollees.

Non-Emergency Services – any care or services that are not considered emergency services as defined in this Contract. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under section 1867 of the Social Security Act.

Non-Emergency Medical Transportation (NEMT) – routine medical transportation to and from Medicaid-covered medical appointments. NEMT includes a ride, or reimbursement for a ride, 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.

Physician Services – health care services that a licensed medical physician provides or coordinates.

Post-stabilization Services – services subsequent to an emergency medical condition that a treating physician views as Medically Necessary after an enrollee's condition has been stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

Potential Enrollee – a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

Pregnant Women or Pregnancy-Related Services – all women receiving related services and services for other conditions that might complicate the pregnancy, unless specifically identified in the Medicaid State Plan as not being related to the pregnancy. This includes counseling for cessation of tobacco use and services during the postpartum period. The pregnancy period for which these services must be covered includes the prenatal period through the postpartum period (including the one year postpartum period following the end of pregnancy covered under West Virginia Code § 9-5-12.

Prescription Drug Coverage – health insurance that helps pay for prescription drugs and medications. Prescription drug coverage is not provided by the MCO. The Department provides outpatient prescription drug coverage directly to Medicaid enrollees.

Prescription Drugs – drugs and medication that, by law, require a prescription.

Primary Care Physician – a doctor who directly provides and coordinates health care services to MCO enrollees.

Primary Care Provider (PCP) – a specific clinician responsible for treating and coordinating the health care needs of certain enrollees.

Primary Services – basic or general health services rendered by general practitioners, family practitioners, internists, obstetricians, and pediatricians.

Prior Authorization/Preauthorization – approval granted for payment purposes by the MCO for its active, specified enrollees, or the Medicaid Program to a provider to render specified services to a specified enrollee.

Provider – an individual or entity that is engaged in the delivery of health services, or ordering or referring for those services, who meets the requirements of the West Virginia Medicaid Program and is enrolled in the MCO's network.

Provider Complaint – any verbal or written expression of dissatisfaction with any aspect of operations or activities of the MCO received by the MCO from a provider through any means regardless of whether the expression of dissatisfaction is resolved immediately, requires investigation and/or further actions, or does not require any remedial action. For purposes of MCO reporting, provider complaints include what may be referred to as "grievances."

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.

Service Authorization – (also Prior Authorization); includes an enrollee's request for the provision of a service.

Skilled Nursing Care – services provided by trained registered nurses (RNs) in a medical setting or enrollee's own home under a doctor's supervision.

Socially Necessary Services (SNS) – Services provided to improve relationships and social functioning, with the goal of preserving the individual's tenure in the community or the integrity of the family or social system. Socially necessary services are interventions designed to maintain or establish safety, permanency and well-being for targeted populations.

Special Investigations Unit (SIU) – a team of program integrity staff responsible for detecting, correcting and reporting fraud, waste and abuse (FWA) across various categories or health care (provider fraud, member fraud and external fraud).

Specialist – a provider who focuses on a specific kind of health care, such as a surgeon or a cardiologist.

Start Date – the date the Contract for services becomes effective.

Subcontract – any written agreement between the MCO and another party to fulfill any requirements of this Contract.

Subcontractor – party contracting with the MCO to perform any services related to the requirements of this Contract. Subcontractors may include, without limitation, affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Subcontractor Monitoring Plan – a written plan describing how the MCO will review obligations, services, and functions performed by the MCO's Subcontractor to ensure that such obligations, services, and functions are performed to the same extent that they would be if performed by MCO.

Supplemental Security Income (SSI) – a Federal income supplement program designed to help aged, blind, and disabled people with little or no income by providing cash to meet basic needs for food, clothing, and shelter.

Systems Quality Assurance Plan – a written plan developed by the MCO that describes the processes, techniques, and tools that the MCO will use for assuring that the MCO information systems meet the Contract requirements.

Targeted Case Management (TCM) – the coordination of services to ensure that eligible Medicaid enrollees have access to a full array of needed services including the appropriate medical, educational, or other services. TCM is responsible for identifying an enrollee's problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist enrollees and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the Medicaid enrollee are addressed on an ongoing basis and that appropriate choices are provided from the 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.

Value-Added Services – services that include additional value benefits that are actual health care services, benefits, or positive incentives that will promote healthy lifestyles and improve health outcomes among enrollees.

2. DELEGATIONS OF AUTHORITY

The West Virginia the Department shall be responsible for administering this contract. The West Virginia Bureau for Medical Services (BMS) within the Department is the single state agency responsible for administering the Medicaid program. The West Virginia BSS within the Department is responsible for the oversight of children within the State's custody, and the administration of SNS. No delegation by either party in administering this Contract will relieve either party of responsibility for carrying out the terms of the Contract.

3. FUNCTIONS AND DUTIES OF THE MANAGED CARE ORGANIZATION

The MCO agrees to perform the functions and duties and fulfill the responsibilities described in Article III, Statement of Work.

4. FUNCTIONS AND DUTIES OF THE STATE

4.1 Eligibility Determination

The Department will determine the initial and ongoing eligibility for services of each enrollee or potential enrollee under this Contract.

4.2 Enrollment

The Department will conduct MCO enrollment process in accordance with 42 CFR §438.54. The Department, either directly or through its designee, will process all enrollments into the MCO. The Department will notify the MCO of such enrollments by means of a daily and monthly enrollment roster report which explicitly identifies those additions who were not enrolled in the MCO during the previous month. The roster will be provided via Secure File Transfer Protocol (SFTP) or electronic media, and will be delivered by the Department to the MCO as soon as possible following the Medicaid Management Information System (MMIS) cut-off date for the month, but not later than the last business day before the end of the month.

4.3 Enrollee Assignment

All eligible children and youth will be enrolled in a single contracted MCO. Enrollees may choose to remain in fee-for-service (FFS) as their alternative delivery system option under this 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 Department is obligated to make payment either by mail or electronic transfer to the MCO. Capitation payments will be made for the month in which services are being provided according to the payment schedule for the month, as set forth in this Contract. The Department reserves the right to change the payment process, but the payment timing described above will remain the same.

Participant population (enrollee months) were developed based on historical FFS participation. CSED waiver enrollee capitation amounts were based on other state experience, PRTF costs, projected service utilization and other factors. The MCO will be paid a capitated rate on a PMPM rate set by the State, which shall be firm and fixed for the period of the contract, subject to any rate adjustments warranted for modifications to State or Federal regulation, waiver amendments, State Plan amendments, etc. In addition, the MCO, serving as an Administrative

Service Organization (ASO), shall be paid a fixed monthly amount for ASO services related to socially necessary services (SNS) administration. This payment shall be issued by the Bureau for Social Services.

4.6 Federal Disallowance

If the federal government recoups money from the State of West Virginia for expenses and/or costs that are deemed unallowable by the federal government, the Department has the right to, in turn, recoup payments made to the MCO for these same expenses and/or costs, even if they had not been previously disallowed by the Department and were incurred by the MCO. Any such expenses and/or costs would then be deemed unallowable by the Department. If the Department retroactively recoups money from the MCO due to a federal disallowance, the Department will recoup the entire amount paid to the MCO for the federally disallowed expenses and/or costs, not just the federal portion.

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work. If the state paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

4.7 Enrollee Eligibility Capitation Adjustments

Changes in enrollee eligibility categories which become known subsequent to payment of a capitation payment will not relieve the MCO of liability for provision of care for the period for which capitation payment has been made.

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.

4.10 Utilization Review and Control

In accordance with 42 CFR §438.210(a)(4), the MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the Medicaid or BSS State Plans, such as medical necessity or for the purpose of utilization control, provided that:

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

The MCO must ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO is prohibited from arbitrarily denying or reducing the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Notwithstanding the above, all covered services must be provided in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements and respective federal regulations.

The Department will have the authority to override any MCO utilization management guideline on a case-by-case basis. The Department Medical Director or BSS designee must coordinate with the MCO Medical Director in the event an override is appropriate based on thorough internal review. The MCO must be responsible for payment should a utilization management guideline be overridden.

4.11 Force Majeure

The MCO will be excused from performance hereunder for any period that it is prevented from providing, arranging for, or paying for services as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

4.12 Time Is of the Essence

In consideration of the need to ensure uninterrupted and continuous MCO performance and service delivery, time is of the essence in the performance of the obligations under this Contract.

4.13 MCO Response Time Frames

The MCO must submit required reports, requests for information, documentation, ad hoc reports, data certification forms, overpayment remittances, or any other item required within the time frames provided by this Contract or by the Department. If an MCO does not submit a required or ad hoc report, requests for information, documentation, data certification form, overpayment remittance, or item required to meet any State or Federal reporting requirements (e.g., provider-preventable conditions [PPCs]) to the Department within the timeframes outlined in this Contract or in the Department's request, the Department may assess liquidated damages on the MCO. The MCO will have a one (1) business day grace period following the due date of the data, report, requests for information, documentation, overpayment remittance, or data certification form. 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.

5.5 Employment/Affirmative Action Clause

The MCO agrees to supply employment/affirmative action information as required for agency compliance with Title VI and VII of the Civil Rights Acts of 1964.

5.6 Hold Harmless

The MCO agrees to indemnify, defend and hold harmless the State of West Virginia and the Department, its officers and employees from and against:

1. Any claims or losses for services rendered by any Subcontractor, person or firm performing or supplying services, materials, or supplies in connection with the

performance of the Contract. The activities of the Fiscal Agent do not constitute the MCO's performance;

2. Any claims or losses to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation, disregard of Federal or State Medicaid statutes or regulations of the MCO, its officers, employees, or Subcontractors in the performance of the contract;
3. Any claims or losses resulting to any person or entity injured or damaged by the MCO, its officers, employees, or Subcontractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data used under the Contract in a manner not authorized by the contract, or by Federal or State statutes or regulations;
4. Any failure of the MCO, its officers, employees, or Subcontractors to observe State and Federal laws, including but not limited to labor and minimum wage laws.

5.7 Confidentiality

The MCO agrees to comply with applicable state and federal law regarding confidentiality/privacy including the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431, Subpart F (42 CFR §431 F); Title 45, Parts 160, 162, and 164; and the Federal Information Security Management Act (FISMA), to the extent they apply.

The MCO agrees that all material and information, and particularly information relative to individual applicants or enrollees of assistance through the Department, provided to the MCO by the State or acquired by the MCO in performance of the Contract whether verbal, written, recorded magnetic media, cards or otherwise will be regarded as confidential information and all necessary steps must be taken by the MCO to safeguard the confidentiality of such material or information in conformance with federal and state statutes and regulations.

The MCO agrees not to release any information provided by the Department or providers or any information generated by the MCO regarding this Contract without the express consent of the Contracting Officer, except as otherwise provided in this Contract.

5.8 Independent Capacity

The MCO, its officers, employees, Subcontractors, or any other agent of the MCO in performance of this Agreement must act in an independent capacity and must not hold themselves out to be officers or employees of the State of West Virginia or of the Department.

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

The MCO must provide staffing of qualified individuals for the required positions and functions in sufficient number to meet the MCO's operational responsibilities. 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) or West Virginia MHP Vice President/Senior Vice President 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 for 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 may report organizationally within the MCO's overall corporate structure.	
Chief Executive Officer (CEO)/Chief Operating Officer (CEO/COO) or Vice President/Senior Vice President	Information Technology (IT) Director
The below key staff must report solely to the West Virginia MHP Chief Executive Officer (CEO)/ Chief Operating Officer (COO) or West Virginia MHP Vice President/Senior Vice President unless otherwise approved by BMS.	
Contract Liaison/Medicaid Administrator	Social Services Director
Chief Financial Officer (CFO)	SNS Liaison
Medical Director	Quality Director
Utilization Management (Utilization Review) Director	Enrollee Services Director
Care Management Director	Claims Payment Director
Behavioral Health Medical Director	Network Development Director
Program Integrity Lead	Community Engagement Director

Key Staff	
CSED Director	Medicaid Enrollee Advocate
Social Determinants of Health Director	Provider Relations Director

The MCO must notify the Department in writing of changes in key staff positions when individuals either leave key positions or are filled within ten (10) calendar days of any change. The MCO must include with the written notice a transition plan (e.g., actions to be taken, estimated timeframes for hiring a replacement, etc.), and provide BMS with updates every thirty (30) days or at an agreed upon frequency until the position is filled. Hiring or replacement of key staff must conform to Contract requirements. The MCO must also provide an updated organizational chart within ten (10) calendar days of request.

All key staff or his or her designee must respond to requests of the Department within three (3) business days.

5.10.1 Key Staff Requirements

The MCO's Key Staff must meet the following requirements, as applicable:

1. The Chief Executive Officer/Chief Operating Officer (CEO/COO) or Vice President/Senior Vice President is responsible for managing overall operations and resources, provides strategic and operational leadership and direction for the organization. The CEO/CCO must directly and with collaboration of subordinates: manage organizational activities; direct public policy, advocacy, and legislative affairs for enrollees; maintain an effective relationship with the Board of Directors; authorize the contract terms and ensure terms are met for the entire contract term; authorize subcontracts as related to the prime vendor contract; and ensure subcontractors meet the terms of the prime contract. The CEO/COO or Vice President/Senior Vice President must be actively involved in management of program operations and actively participate in meetings with BMS.

   The CEO/COO or Vice President/Senior Vice President must have at least five (5) years' experience serving as an executive manager for a managed care entity or other health insurance provider, a Bachelor's degree or higher and be based in West Virginia.

2. The Contract Liaison/Medicaid Administrator is responsible for overall delivery of the project, serving as a liaison with BMS during all contract phases. The Administrator must attend in person, upon BMS request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. The Administrator must: establish and maintain a positive client relationship; provide timely and informed responses to operational and administrative inquiries; make contractual, operational, and financial decisions, including, but not limited to, claims payment, and provider relations/contracting; and, meet with BMS staff or other person(s) as designated by BMS on a regular basis to provide oral and written status reports and other information as required. The Administrator must respond to issues involving information systems and reporting, appeals, quality improvement, member services, service management,

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, and a Bachelor's degree or higher.

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 and/or commercial insurance program and five (5) years' experience working in adult or pediatric primary care, an active West Virginia Medical License and availability to be on-site in West Virginia as requested by the Agency.

5. The Utilization 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 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 enrollee's PCP, referral processes for Medically Necessary and socially necessary

services (SNS), provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, care management of children with serious emotional disorders, and health risk assessment completion. The CM Director establishes and monitors care coordination staffing ratios and related activities, and oversees the continuity and coordination of care of enrollees.

The CM Director must have at least five (5) years' experience working as a case manager or care coordinator for a Medicaid program, at least one (1) year experience in administering a CSED waiver program, credentialed as a RN, NP, PA, LPC, and/or be a LSW in West Virginia and must be based in West Virginia.

7. The Behavioral Health (BH) Medical Director is responsible for oversight of behavioral health clinical and quality activities of the project. The BH Medical Director shall be available for behavioral health service utilization review decisions and shall be authorized and empowered to respond to behavioral health clinical issues, utilization review, and behavioral quality of care inquiries. The BH Medical Director must attend in person, upon Agency request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers.

   The BH Medical Director must have at least five (5) years' experience in serving as Behavioral Health Lead or Expert for a Medicaid and/or commercial insurance program and five (5) years' experience working in behavioral health clinical care, including trauma and substance use. The BH Medical Director must hold an active, unrestricted West Virginia medical license as a psychiatrist and have availability to be on-site in West Virginia as requested by the Department.

8. The Social Services Director shall be an expert in Multidisciplinary Team (MDT) efforts, and shall serve as the Child Protective Services (CPS) Coordinator. The Director performs oversight of activities relating to social services referrals, connections, and services, serves as the MCO's subject matter expert (SME) related to MDTs and CPS. The Director shall serve as a resource to caseworkers throughout the MDT process to facilitate appropriate and effective treatment options, oversee and collaborate with the SNS Liaison and ensure organizational awareness and connectivity to social services and CPS resources for the population.

   The Director must have at least three (3) years' experience in supporting a child welfare program, interacting with local and state social services agencies, and strong understanding of behavioral health needs of vulnerable children, youth, and families requiring specialized care. The Director must have a Master Level Social Worker (MSW), LPC, or LCSW in West Virginia and be based in West Virginia.

9. The SNS Liaison is responsible for coordinating all SNS. The Liaison shall monitor the utilization of SNS and ensure access to SNS, collaborate and interface with BSS and all SNS providers to facilitate enrollee access to care and positive health and social outcomes to maintain safety, permanency, and well-being. The Liaison shall support the administration of retrospective reviews of SNS providers.

   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.

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 payment arrangements and APMs, oversees physical health and behavioral health provider contracting documents and addenda, supports the oversight of physical health and behavioral health provider credentialing activities and reports to BMS on access to care and network development needs for SNS providers.

The Director must have at least five (5) years' experience serving as a network manager in a health insurance role.

14. The Provider Relations Director is responsible for interfacing with the provider community and supports ongoing provider relationships. The Director monitors and responds to provider inquiries, complaints, and communications, develops training for contracted providers and their staff in relation to the requirements of this contract and the special needs of the population, and designs, develops, and implements an annual provider satisfaction survey. The Director ensures the development, distribution, and maintenance of a provider manual.

    The Director must have at least five (5) years' experience in serving as a provider relations manager or specialist in a health insurance role and be based in West Virginia.

15. The Program Integrity Lead is responsible for all compliance, program integrity, and fraud-related activities. The Lead creates internal controls, policies, and procedures to prevent and detect fraud and abuse, develops a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones, establishes and maintains a Special Investigations Unit (SIU) to investigate possible acts of fraud, waste, or abuse (FWA) for all services provided under the contract and serves as the primary contact person for all Department Program Integrity and Medicaid Fraud Control Unit (MFCU) record requests. The Lead monitors provider fraud for underutilization of services and enrollee/provider fraud for overutilization of services, establishes written policies and procedures for maintaining the confidentiality of data to protect members from unauthorized disclosures.

    The Lead must have at least three (3) years' experience working on fraud and/or integrity projects, a bachelor's degree or higher, or equivalent experience.

16. The Information Technology (IT) Director is responsible for all systems, data, and hardware activities. The Director is required to submit reports, requests for information, documentation, ad hoc reports, data certification forms, or any other data required as requested by the BMS within the time frames provided by the contract and maintains reasonable safeguards against the destruction, loss, or alteration of any data in the possession of the MCO. The Director manages systems configuration, testing, and implementation activities, maintains a health information system that collects, integrates, analyzes, and reports necessary data for reporting purposes, oversees all systems-related activities, including the MCO's Electronic Medical Record (EMR), claims processing system, provider data system, etc.

    The Director must have at least five (5) years' experience working in IT solutions in healthcare, with an emphasis in data integrity and at least a bachelor's degree.

17. The Community Engagement Director is responsible for marketing, public relations, and community engagement activities. The Director must develop and maintain Medicaid marketing policies and procedures in adherence to state and federal regulations and 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 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.

19. 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.

20. The Social Determinants of Health Director is responsible for leading the MCO's efforts to address to improve population health outcomes. The Director must lead development and implementation of initiatives to further equitable healthcare among membership. The Director must chair the MCO's Social Determinants of Health 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 have a Bachelor's degree or higher. The Director must be available to be onsite in West Virginia as requested by BMS.

5.11 Location of Operations

The MCO is required to have a physical presence in West Virginia, including: ensuring at least eighty (80) percent of its total full-time equivalent positions allocated to manage care of individuals covered under this contract have a primary work place in the state of West Virginia and the operation of call center services is in a West Virginia location. The MCO must notify the Department forty-five (45) calendar days in advance of any proposal to modify claims operations and processing, enrollee services, or case management processes that may include the relocation of operations. The MCO must be responsible for any costs incurred by other contracted vendors of the Department for required updates needed as a result of such change.

5.12 Communication with the Department

The MCO must acknowledge receipt of the Department's written, electronic, or telephonic information requests as expeditiously as the matter requires or no later than two (2) business days after receipt of the request from the Department. The MCO's information request acknowledgment must include a planned date of information request resolution. A detailed resolution summary advising the Department of the MCO's action and resolution must be rendered to the Department in the format requested.

The Department's urgent information requests such as issues involving legislative inquiries, inquiries from other governmental bodies, or urgent inquiries as determined by the Department, must be given priority by the MCO and completed in accordance with the information request or instructions from the Department. The Department will provide guidance with respect to any necessary deadlines or other requirements. A resolution summary, as described by the Department, must be submitted to the Department.

MCO's failure to communicate complete, meaningful, and timely responses to all Department's information requests may result in remedies as described in Article II, Section 6 and Appendix F of this contract.

5.13 Waivers

No covenant, condition, duty or obligation, or undertaking contained in or made a part of this Contract will be waived except by the written agreement of the parties.

5.14 Compliance with Applicable Laws, Rules, And Policies

The MCO and its Subcontractors, in performing this contract, must comply with all applicable Federal and State laws, regulations, and written policies, including those pertaining to licensing and including those affecting the rights of enrollees. The MCO must include provisions relating to compliance with such laws in Subcontracts with providers. Assessment of compliance must be included in the MCO's credentialing procedures to the extent feasible.

Work performed under this Contract must conform to the federal requirements set forth in Title 45, CFR Part 74 and Title 42, Part 434. The MCO must also abide by all applicable Federal and State laws and regulations including but not limited to:

- 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:

- For which funds may not be used under ASFRA of 1997; and
- For roads, bridges, stadiums, or any other item or service not covered under the State Plan.

The MCO must comply with all applicable Federal and State laws, regulations, policies, or reporting requirements needed to comply with the policies and regulations set forth in the PPACA, P.L. 111-148, enacted on March 23, 2010, and the HCERA, P.L. 111-152, enacted on March 30, 2010.

The MCO must also comply with requirements and regulations pertaining to:

- Copyrights, data, and reporting and patent rights under any Contract involving research, developmental, experimental, or demonstration work with respect to any discovery or invention which arises or is developed in the course of this contract;

- Applicable standards, orders, or requirements under Section 306 of the Clean Air Act (42 USC 1857(h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15); and
- Energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P.L. 94-165).

The MCO must procure all necessary permits and licenses and abide by all applicable laws, regulations, and ordinances of the United States, State of West Virginia, and political subdivision in which work under the Contract is performed.

The MCO must retain at all times during the period of this Contract a valid Certificate of Authority issued by the State Commissioner of Insurance.

The MCO must pay any sales tax, use and personal property taxes arising out of this Contract and the transactions contemplated thereby. Any other taxes levied upon this contract, the transaction, or the equipment or services delivered pursuant hereto will be borne by the MCO.

The MCO must adhere to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578.

The MCO must fully comply with W. Va. Code §11-27-10a which imposes a tiered tax on a PMPM basis on all entities holding a health maintenance organization (HMO) certificate of authority in the State of West Virginia.

The MCO must fully comply with any relevant requirements of the Implementation Plan of the Memorandum of Understanding Between the State of West Virginia and the United States Department of Justice.

5.15 Non-discrimination

The MCO must comply with all Federal and State laws relating to non-discrimination, including but not limited to: Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 CFR Part 80 or 7 CFR Part 15; Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.); Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688); Food Stamp Act of 1977 (7 U.S.C. §200 et seq.); Executive Order 11246 and its implementing regulations at 41 CFR Part 60; Executive Order 13279, and its 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 facilities (but not salaries paid to employees); and (3) any loans or extensions of credit. The MCO must make the information reported available to its enrollees upon reasonable request.

The MCO will covenant that it, its officers or enrollees, employees, or Subcontractors will not acquire any interest, direct or indirect which would conflict or compromise in any manner or degree with the performance of its services hereunder. The MCO further covenants that in the performance of the contract, the MCO must periodically inquire of its officers, enrollees, and employees concerning such interests. Any such interests discovered must be promptly presented in detail to the Department.

5.19 Department's Data Files

The Department's data files and data contained therein will be and remain the Department's property and must be returned to the Department by the MCO upon the termination of this Contract at the Department's request, except that any Department data files no longer required

by the MCO to render services under this Contract must be returned upon such determination at the Department's request.

The Department's data will not be utilized by the MCO for any purpose other than that of rendering services to the Department under this contract, nor will the Department's data or any part thereof be disclosed, sold, assigned, leased, or otherwise disposed of to third parties by the MCO unless there has been prior written Department approval.

The Department must, upon request to the MCO, have the right of access and use of any data files retained or created by the MCO for systems operation under this contract.

The MCO shall have a process to accommodate files that are larger than its email capacity for sending any documents related to contracts, procurement, and routine work to the Department or designee. This process also includes secure mail capabilities when appropriate.
The MCO must establish and maintain at all times reasonable safeguards against the destruction, loss, or alteration of the Department's data and any other data in the possession of the MCO necessary to the performance of operations under this contract.

5.20 Changes Due to a Section 1915(b) Freedom of Choice, 1915(c) Home and Community-Based, or 1115 Demonstration Waiver

The conditions described in the contract, including, but not limited to enrollment and the right to disenrollment, are subject to change as provided in any waiver under section 1915(b), 1915(c), or 1115 of the Social Security Act (as amended) obtained by the Department.

5.21 Contracting Conflict of Interest Safeguards

The MCO asserts that to the best of its knowledge that the process of procuring this Contract has been compliant with the federal contracting requirements set forth in 41 U.S.C. 423 and 42 CFR §438.3.

The MCO must not pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value to an employee or agent of the State of West Virginia with the intent to influence work related to the Contract.

5.22 Prohibition Against Performance Outside the United States

The MCO and a Subcontractor must comply with the requirements of Section 6505 of the PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the 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
- Represents a failure of the MCO to be reasonably responsive to a reasonable request of the Department for information, assistance, or support within the timeframe specified by the Department.

Non-performance of this Contract includes, but is not limited to:

- Failing substantially to provide Medically Necessary covered services that the MCO is required to provide, under law or under its Contract with the Department, to an enrollee covered under the Contract;
- Failing substantially to provide covered SNS that the MCO is required to provide, under law or under its Contract with the Department, to an enrollee covered under the Contract;
- Imposing premiums, copays, or charges that are in excess of the premiums, copays, or charges permitted under the Medicaid program;

- Acting to discriminate among enrollees on the basis of their health status or need for health care services, including terminating of enrollment or refusal to reenroll an individual, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;
- Misrepresenting or falsifying information that the MCO furnishes to CMS, ACF, or to the State;
- Misrepresenting or falsifying of information that the MCO furnishes to an enrollee, potential enrollee, health care provider or SNS provider;
- Distributing directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;
- Failing to maintain an adequate network of properly credentialed providers;
- Failing to comply with the provider reimbursement requirements of this Contract;
- Failing to comply with the reporting requirements of this Contract;
- A pattern of inappropriately denying payments for emergency-related services; or
- Violating the requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

6.2 Corrective Action Plan (CAP)

At its option, the Department may require the MCO to submit to the Department or its designee a written plan (the "Corrective Action Plan (CAP)") to correct or resolve non-performance of the Contract, as determined by the Department.

1. The CAP must provide:
    a. A detailed explanation of the reasons for the MCO's non-performance;
    b. The MCO's assessment or analysis of the cause, if applicable; and
    c. A specific proposal to cure or resolve the non-performance.
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;
- Imposing premiums, copays, or charges to enrollees in excess of the premiums, copays, or charges permitted under the Medicaid program;
- Engaging in any practice that discriminates on the basis of health status or need for health care services;
- Misrepresenting or falsifying information furnished to the Department, an enrollee, a potential enrollee, or health care provider;
- Failing to comply with the physician incentive requirements under section 1903(m)(2)(A)(x) of the Social Security Act; or
- Distributing directly or through any agent or independent contractor marketing materials that contain false or misleading information.

The Department must notify the CMS Regional Office and ACF at any time any of the above conditions are found to exist or as appropriate at any time the MCO:

- Is found to have performance deficiencies in any of the above areas;
- Is under a CAP;
- Has been assessed liquidated damages;
- Has had enrollment suspended;
- Has had temporary management appointed by the State;
- Has had payments suspended;
- Is engaged in dispute resolution;
- Is being terminated for default; or
- Is otherwise non-compliant or has a performance deficit as described in Article II, Section 6 of this contract.

Unless otherwise specified in the written notice of condition(s) that endanger performance, the Department, in its sole discretion, may allow the MCO an allotted amount of business days to remedy the condition(s) contained in the notice. If after such notice of conditions that endanger performance the MCO fails to remedy the conditions contained in the notice, within ten (10) business days or the time period specified in the notice, the Department may pursue other remedies under this Contract or any intermediate remedies outlined in 42 CFR §438.702.

If BMS determines that it will terminate the MCO for reasons set forth in 42 CFR § 438.708, BMS must provide the MCO a pre-termination hearing in accordance with 42 CFR § 438.710:

- Provide the MCO written notice of the intent to terminate, the reason for termination, and the time and place of the hearing.
- After the hearing 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 consistent with 42 CFR § 438.10, about enrollees' options for receiving covered services following the termination, and the right to terminate enrollment in the MCO immediately without cause.

6.4 Failure to Meet Contract Requirements

The MCO must comply with all requirements and performance standards set forth in this Contract. The MCO agrees that failure to comply with all provisions of the Contract may result in the assessment of remedies and/or termination of the Contract, in whole or in part, in accordance with this Article. The MCO agrees and understands that the Department may pursue contractual remedies for non-performance under the Contract. At any time and at its discretion, the Department may impose or pursue one or more remedies for each item of non-performance and will determine remedies on a case-by-case basis.

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.

6.5 Temporary Management

The State must appoint temporary management as a remedy under the circumstances described in 42 CFR §438.706 and 42 CFR §438.704, if the State determines that the MCO has repeatedly failed to meet the substantive requirements in Sections 1903(m) or 1932 of the Social Security Act and that the continued operation of the MCO would be hazardous to enrollees. The Commissioner of the Offices of the Insurance Commissioner (OIC) will be responsible for the imposition of such remedy as set forth in Section 33-25A-19 of the West Virginia HMO Act of 1977. If temporary management is imposed, the State will notify enrollees of their right to terminate enrollment in the MCO.

The State may terminate the Contract and provide their enrollees' Medicaid and SNS benefits through other options included in the applicable State Plans or waivers.

Nothing precludes the Department's right to appoint temporary management during the time in which the MCO is remedying the condition(s) or while an appeal requested by the MCO is pending. However, before any temporary management is appointed, the Department will notify, in writing, the MCO of the specific non-performance. Within ten (10) business days of receipt of this written notification, the MCO will forward a plan to remedy this non-performance to the Department. The Department will, as soon as possible, notify the MCO whether it agrees to the plan, and if so, the MCO will immediately begin to remedy the non-performance in accordance with the plan, and will have fifteen (15) business days to do so. If the plan is not accepted, such reasons will be given, and the MCO will revise the plan to reflect the Department's changes, and then will resubmit and immediately begin to remedy the non-performance and will have fifteen (15) business days to do so.

6.6 Suspension of New Enrollment

Whenever the Department determines non-performance by the MCO under this Contract, the Department may suspend enrollment of new enrollees into the MCO under this Contract. The Department, when exercising this option, must notify the MCO in writing of its intent to suspend new enrollment at least ten (10) business days prior to the beginning of the suspension period in accordance with Article II, Section 6.8. The suspension period may be for any length of time specified by the Department, or until the non-performance is remedied, or for an unspecified time period. The suspension period may extend up to the Contract expiration date as provided under Article I. The Department may grant MCO enrollees the right to terminate enrollment without cause and to notify the affected enrollees of their right to disenroll.

6.7 Payment Suspension

The Department may suspend portions of capitation payments from the MCO as a remedy for non-performance. Whenever the Department determines that the MCO has failed to provide one (1) or more of the covered Contract services, the Department may suspend an estimated portion of the MCO's capitation payment in subsequent months. Such suspension amount will be equal to the amount of money the Department expected the MCO to pay for covered Contract services, plus any administrative costs involved. The MCO may not deny any covered Contract services in order to receive adjusted payment levels. The MCO will be given written notice at least ten (10) business days prior to the suspension of any capitation payment in accordance with Article II, Section 6.8.

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 to 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.

6.9 Termination For Default

The State of West Virginia, Department of Administration Purchasing and/or the Department may terminate performance of work under this Contract in whole, or in part, whenever the MCO defaults in performance of this Contract and fails to cure such default or make progress satisfactory to the Department toward Contract performance within a period of thirty (30) calendar days after receipt of notice of default (or such longer period as the Department may allow). Such termination will be referred to herein as "Termination for Default."

Events constituting a Termination for Default include, but are not limited to:

1. MCO insolvency or the MCO's failure to meet its financial obligations as they become due;
2. MCO failure to pay claims;
3. Untimely service authorizations or other acts or omissions of the MCO or its Subcontractors resulting in a substantial risk to the health of the enrollees;
4. The MCO or its Subcontractors, affiliates or agents are expelled or suspended from federal health insurance programs under Title XVIII or Title XIX of the Social Security Act;
5. Any action taken by the West Virginia OIC deemed by the Department to adversely affect the ability of the MCO to provide healthcare services to its enrollees;
6. Failure of the MCO to obtain signed provider agreements, Subcontractor agreements or agreements with other agents of the MCO that impairs the ability of the MCO to perform the services under the Contract and failure to cure within thirty (30) calendar days or such longer period as the Department may allow;
7. The MCO misrepresents, omits, or otherwise falsifies information or the MCO knowingly permits its Subcontractors, affiliates, or agents to provide fraudulent, intentionally misleading or misrepresentative information; or
8. Breach of any covenant contained in the Contract and failure to cure such covenant default within thirty (30) calendar days or such longer period as the Department may allow

If the MCO defaults in the performance of the duties under the Contract, the Department may exercise remedies including, but not limited to:

1. Suspension of enrollment;
2. Suspension of capitation payments;
3. Appointment of a management company to oversee the operations of the MCO;
4. Imposition of civil and monetary damages;
5. Pursuit of any other remedy permitted by law; or
6. Termination of the Contract.

Before terminating the contract, the State will provide the MCO with a pre-termination hearing.

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.

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:

1. At the Contract price(s) for services delivered to and accepted by the Department.
2. At a price mutually agreed to by the MCO and the Department for services partially completed.

6.11 Termination Due to Change in Law, Interpretation of Law, or Binding Court Decision

Any change in Federal or State law, or any interpretation of law by the United States DHHS or by a court whose decisions constitute binding precedent in West Virginia, which significantly alters the MCO's required activities or any change in the availability of funds, will be viewed as

binding and will warrant good faith renegotiation of the provisions of the Contract that are thus affected. If such renegotiation proves unsuccessful, the Contract may be terminated on written notice of either party to the other party at least thirty (30) calendar days prior to termination.

6.12 Termination for Managed Care Organization Bankruptcy

In the event of the filing of a petition in bankruptcy by or against the MCO, the State of West Virginia, Department of Administration Purchasing through the Department will have the right to terminate the Contract upon the same terms and conditions as a Termination for Default.

6.13 Termination for Unavailability of Funds

The State of West Virginia, Department of Administration Purchasing through the Department at its discretion, may terminate at any time, the whole, or any part of, this Contract or modify the terms of the Contract if federal or state funding for the Contract, the Medicaid program, or the Foster Care program as a whole is reduced or terminated for any reason. Modification of the Contract includes, but is not limited to, reduction of the rates or amounts of consideration, reducing services covered by the MCO, or the alteration of the manner of the performance in order to reduce expenditures under the contract. Whenever possible, the MCO will be given thirty (30) calendar days notification of termination.

After modification of the contract, the MCO will have the right not to continue the Contract if the new Contract terms are deemed to be insufficient, notwithstanding any other provision of this contract. The MCO will have a minimum of sixty (60) calendar days to notify the State of West Virginia, Department of Administration Purchasing through the Department regarding its desire to accept new terms. If the new capitation rates and any other Contract modifications are not established at least sixty (60) calendar days prior to the expiration of the initial or extension agreement, the Department will reimburse the MCO at the higher of the new or current capitation rates for that period during which the new agreement period had commenced and the MCO's sixty (60) calendar day determination and notification period had not been completed, and the MCO will be held to the terms of the executed contract.

If the Department is not allotted funds in any succeeding fiscal year for the continued use of the services covered by this contract, the Department may terminate the Contract pursuant to Article II, Section 6, hereof at the end of the affected current fiscal period without further charge or penalty. The Department is obligated to pay all charges incurred through the end of the fiscal year at which time this Contract will terminate. The Department must give the MCO written notice of such non-allocation of funds as soon as possible after the Department receives notice of such non-allocation. No penalty may accrue to the MCO in the event this provision is exercised.

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, documentation or information is not accurate, complete, or HIPAA-compliant, the Department reserves the right to hire an independent contractor to assist the Department in obtaining and transferring all the required data and information, and to ensure that all of the data is Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant. The MCO is responsible for the reasonable cost of providing these services.

The MCO must maintain a Transition Plan covering the turnover of the program records and information maintained to either the Department or a subsequent contractor. The Transition Plan must be a comprehensive document detailing the proposed schedule, activities, information, and resource requirements associated with the turnover tasks. The Department reserves the right to review the MCO Transition Plan and any significant modifications to the previously approved

Transition Plans. The Department reserves the right to provide CMS and ACF as appropriate with Transition Plan documentation upon request.

The MCO must transfer to the Department or a subsequent contractor all data and information necessary to transition operations, including: data and reference tables; data entry software; third-party software and modifications; documentation relating to software and interfaces; functional business process flows; and operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors. In addition, the MCO must provide the following to the Department or a subsequent contractor:

- The MCO must provide data, information, and services necessary and sufficient to enable the Department to map all MCO data from the MCO's system(s) to the replacement system(s) of Department or a successor contractor, including a comprehensive data dictionary as defined by the Department.
- The MCO must provide all necessary data, information, and services in the format defined by Department, and HIPAA-compliant.
- The MCO must provide all of the data, information, and services mentioned in this section using its best efforts to ensure the efficient administration of the Contract. The data and information must be supplied in the media format specified by Department and according to the schedule approved by Department in the Transition Plan.
- If the MCO does not provide the required data, information, documentation or services necessary for the Department or the subsequent contractor to assume the operational activities successfully, the MCO must reimburse the Department for all reasonable costs and expenses, including transportation; lodging; subsistence to carry out inspection, audit, review, analysis, reproduction, and transfer functions at the location(s) of any necessary records; and attorneys' fees and costs.

This provision does not limit the Department's ability to impose remedies as set forth in the Contract.

6.16 Cooperation with Other Contractors and Prospective Contractors

The MCO must cooperate with other Department contractors, including other MCOs and will not commit or permit any act that may interfere with the performance of work by any other contractor or prospective MCO.

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.

8. OTHER REQUIREMENTS

8.1 Inspection of Facilities

The MCO and its Subcontractors must provide the State of West Virginia, CMS, ACF, the Office of the Inspector General (OIG) and any other legally authorized governmental entity or their authorized representatives, the right to enter the MCO's and its Subcontractors' premises, physical facilities and equipment or other places where work under this Contract is performed to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract. The State of West Virginia, CMS, ACF, the OIG, the Comptroller General, their designees, and any other legally authorized governmental entity may conduct such inspections and record/documentation audits at any time.

The MCO and its Subcontractors must provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties (e.g., assistance from MCO staff to retrieve and/or copy materials). The Department and its authorized agents will request access in writing except in case of suspected fraud, waste, and abuse (FWA). All inspection, monitoring,

and evaluation must be performed in such a manner as not to unduly interfere with the work being performed under this contract.

In the event that right of access is requested under this section, the MCO or its Subcontractors must, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort.

All inspections or audits will be conducted in a manner that will not unduly interfere with the performance of the MCO or any Subcontractors' activities. The MCO and its Subcontractors will be given ten (10) business days to respond to any findings of an audit before the Department will finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

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

8.2 MCO Requirements Related to Information Systems and Other Technology

The MCO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The MCO must develop and maintain the following documents:

1. Information Security Plan;
2. Systems Quality Assurance Plan;
3. Interoperability and Patient Access Plan; and
4. Health Information Systems Strategy.

The MCO must provide a copy of these documents within ten (10) business days of written request from the Department.

The MCO must be protected against hardware and software failures, human error, natural disasters, and other emergencies which could interrupt services. The MCO must develop and maintain at all times a detailed HIPAA compliant Business Continuity Plan (BCP) for all 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 from the date the written findings report is submitted to BMS. The MCO must repeat the testing upon completion of the CAP, and submit results of re-testing to BMS within fifteen (15) calendar days of the date the retesting is conducted. 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.

The MCO shall have in place a technology-enabled strategic plan that outlines the MCO's approach for engaging and educating enrollees, as well as improving access to care and services through telehealth services and web-based applications.

The MCO must sign the BMS-supplied Business Associate Agreement (BAA) to comply with regulations concerning the safeguarding of protected health information (PHI) and electronic protected health information (ePHI).

8.3 Maintenance and Examination of Records

The MCO and its Subcontractors must maintain records, books, documents, papers, and files that are related to West Virginia's managed care program services and expenditures, including reports to the Department and source information used in preparation of these reports. These

reports include but are not limited to financial statements, records relating to quality of care, and medical records. In addition, the MCO must provide, and cause its Subcontractors to provide, at no cost to the Department or a designee, prompt, reasonable, and adequate access to any records, books, documents, papers, and files that are related to performance under the Contract. The MCO and its Subcontractors agrees to permit inspection of its records, books, documents, papers, and files which will be conducted in accordance with Federal and State laws and regulations regarding confidentiality. The MCO and its Subcontractors are required to submit information to the Department or to a designee in a manner that maintains the confidentiality of involved parties (e.g., blacking out enrollees' and providers' names). The MCO must comply with the record retention requirements of Title 45, Sections 74.21 through 74.23 (45 CFR §74.21 through §74.23) and FISMA. Such records, with the exception of medical records and enrollee and provider quality assurance and quality improvement records when confidentiality is protected by law, are the property of the Department.

CMS, the OIG, the Comptroller General, the Secretary, the Department or their designees have the right to audit and inspect any books or records of the MCO or its Subcontractors pertaining to the ability of the MCO to bear the risk of financial losses and services performed or payable amounts under the Contract.

Upon non-renewal or termination of this Contract, the MCO must turn over, and cause its Subcontractors to turn over, to the Department or to a designee of the Department all records, books, documents, papers and files that are related to persons receiving services and to the administration of this Contract that the Department may request.

The MCO must provide, and cause its Subcontractors to provide, CMS, OIG, the Comptroller General, the Department and its authorized agents with reasonable access to any records, books, documents, papers, and files the MCO and its Subcontractors maintain for the purposes of this Contract. The Department and its authorized agents will request access in writing except in cases of suspected FWA. The MCO and its Subcontractors must make all requested medical records available within ten (10) business days of the Department' request.

Any Subcontract with an approved MCO Subcontractor must include a provision specifically authorizing maintenance and examination of records in accordance with the terms set forth in this section.

8.4 Audit Accounting and Retention of Records

The Department may, at its option, conduct an audit of the MCO's and its Subcontractors' operations as they pertain to services and recoveries pursuant to the contracted services.

The MCO and its Subcontractors, for purposes of audit, must provide the State of West Virginia, the Secretary of the U.S. DHHS, the OIG, the Comptroller General and his/her designees, and any other legally authorized governmental entity or their authorized agents access to all the MCO 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, enrollee grievance and appeal records in 42 CFR §438.416, base data in 42 CFR §438.5(c), Medical Loss Ratio (MLR) reports in 42 CFR §438.8(k), and the data, information and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610. The State, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documentations of the MCO for the ten (10) year period from the final date of the contract period or from the completion of any audit, whichever is later.

8.5 Subcontracts

The MCO may enter into a Subcontract agreement to fulfill the requirements of this Contract. Subcontracts must comply with the requirements of 42 CFR §434.6 and 42 CFR §438.230. Prior to delegating functions of the Contract, the MCO must evaluate the Subcontractor's ability to perform the functions.

All Subcontracts must be in writing and include the ability for the MCO to revoke the Subcontract or impose sanctions if the Subcontractor's performance is inadequate. The MCO must provide the Department or its authorized agents the right to examine any current or former Subcontract and all Subcontractor records relating to this Contract at any time. A Subcontract, or any other agreement in which the MCO receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, or any other consideration from a Subcontractor or any other third party as related to this Contract must be in writing and agreed upon in compliance with the MCO's Contract obligations. The MCO must allow the State, CMS, the OIG, the Comptroller General, and their designees or its authorized agents to examine the Subcontractor agreement and all related records, including the ability to inspect and audit any records or documents.

The MCO Subcontract agreement must include any applicable requirements of this Contract that are appropriate to the services being provided and must assure that all delegated duties under the Subcontract are performed to the same extent as if such were performed by the MCO. Subcontracts must not terminate legal liability of the MCO under this Contract including but not limited to Article II, Section 6 of this Contract. The Department reserves the right to review all Subcontracts and/or any significant modifications to previously approved Subcontracts. The MCO is required to submit utilization review and claims processing Subcontracts ninety (90) calendar days prior to the effective date of the Subcontract for the Department review and approval.

The MCO may not modify, convey, sell, transfer, assign, delegate, or otherwise dispose of the Contract or any portion thereof or of any right, title, or interest therein without the prior written consent of the Department. This provision includes reassignment of the Contract due to change in ownership of the MCO. The Department in its discretion may grant such written approval of an assignment, transfer, delegation, or Subcontract, provided, however, that this paragraph may not be construed to grant the MCO any right to such approval. This paragraph may not be construed as restricting the MCO from entering into contracts with participating providers to provide health care services to plan enrollees.

The Department reserves the right to require the replacement of any Subcontractor found by the Department to be unacceptable and unable to meet the requirements of the Contract and to object to the selection of a Subcontractor. The Department reserves the right to require the CAP for any Subcontractor found by the Department to be unable to meet the requirements of this Contract.

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.

8.6 Insurance

The MCO, its successors and assignees must procure and maintain such insurance as is required by currently applicable federal and state law and regulation. Such insurance must include, but not be limited to, the following:

1. Liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the MCO, its agents and employees;

2. Fidelity bonding of persons entrusted with handling of funds;
3. Workers' compensation; and
4. Unemployment insurance.

The MCO may obtain a reinsurance policy, or establish a restricted fund balance for the purpose of self-insurance, to ensure maintenance of adequate capital by the MCO for the financial risks that are accepted by the MCO throughout this Contract. The MCO must assume full financial risk on a prospective basis for the health care services required in this Contract.

If the MCO obtains a reinsurance policy, the reinsurance arrangement will be subject to Department approval. The MCO must provide the Department with a complete copy of the reinsurance policy, which specifies the costs and coverages of the reinsurance policy. The MCO must not obtain a reinsurance policy from an offshore company; the insurance carrier, the insurance carrier's agents, and the insurance carrier's subsidiaries must be domestic. The Department can request additional documentation, as needed, to verify the reinsurance policy was obtained from a domestic company.

The Department can perform audits on reinsurance claims. Terms of the audit process will be disclosed prior to the audit. The MCO will be provided appropriate advanced notice of the reinsurance claims audit.

The MCO must be in compliance with West Virginia Code § 33-25A-4(2)(f) and 42 CFR § 438.116.

8.7 Disclosure of Ownership

The MCO, as a "disclosing entity," must supply the Department with full and complete information of each person (individual or corporation) with an ownership or control interest in the MCO or the MCO's Subcontractor in which the MCO has direct, or indirect ownership as outlined below and in accordance with 42 CFR §455.104.

The MCO and its subcontractors are required to disclose to the state any persons or corporations with an ownership or control interest in the MCO that:

1. Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the MCO's equity;
2. Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the MCO if that interest equals at least five percent (5%) of the value of the MCO's assets;
3. Is an officer or director of an MCO organized as a corporation; or
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.

For the purposes of this Section, a "relationship" is defined as follows:

1. A director, officer, or partner of the MCO;
2. A Subcontractor of the MCO, as governed by 42 CFR 438.230;
3. A person with beneficial ownership of five percent (5%) or more of the MCO's equity;

4. A network provider or person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under this contract.

The MCO may not have a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the MCO and who:

- Has been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3), of the Social Security Act;
- Has had civil money penalties or assessments imposed under section 1128A of the Social Security Act; or
- Has been excluded, suspended, or debarred from participation in Medicare or any state health care programs.

The MCO must submit information as described above, for any person who was formerly described as a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the MCO, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

The MCO must immediately inform the Department of any circumstances that are grounds for its exclusion, or the exclusion of its contracted providers, from participation in the Medicaid program, in accordance with 42 CFR §1001.1001 and 42 CFR §1001.1051.

At the time of Contract and Contract renewal or upon written request by the Department, the MCO must submit information on any person who is a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the MCO and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs, as required in 42 CFR §455.106.

If the Department finds that the MCO is not in compliance with this provision, the Department: (1) will notify the Secretary of the DHHS of such noncompliance; (2) may discontinue the existing agreement with the MCO if so directed by the Secretary (in consultation with the Inspector General of the DHHS); and (3) will not renew or otherwise extend the duration of the existing agreement with the MCO unless the Secretary (in consultation with the Inspector General) provides to the Department and to Congress a written statement describing compelling reasons that exist for doing so.

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.

2. COVERED SERVICES

2.1 Covered MCO Services

The MCO must provide to enrollees under this Contract, directly or through arrangements with others, all of the covered services described in Contract Appendix A (Description of Covered and Excluded Services). Contract Appendix A presents an explanation of the medical, dental, behavioral health, and residential services, which the MCO is required to provide, as well as those which are excluded. It also includes the types of SNS services provided through the ASO. However, the Medicaid policy is the final source for defining Medicaid covered services. Medicaid policy collectively refers to documents and other written materials including the State

Medicaid plan, applicable Medicaid waivers, program instructions, attendant provider manuals, program bulletins, and all published policy decisions issued by BMS. These Medicaid materials are available through BMS. The Title IV State Plan is the final source for defining services covered under the child welfare umbrella.

The MCO must promptly provide or arrange to make available for enrollees all Medically Necessary and SNS listed in Contract Appendix A. The MCO shall be financially responsible for the coverage of all Medicaid services as defined by Appendix A. The MCO is responsible for determining whether services are Medically or Socially Necessary and whether the MCO will require prior approval for services. Qualified medical personnel must be accessible twenty-four (24) hours each day, seven (7) days a week, to provide direction to patients in need of urgent or emergency care. Such medical personnel include, but are not limited to, physicians, physicians on-call, PAs, licensed practical nurses (LPNs), and registered nurses (RNs). The MCO is also responsible for providing emergency transportation as outlined in Article III, Section 2.2.4 and in Appendix A.

Additionally, the MCO's providers must meet the provider requirements as specified by the West Virginia Medicaid program.

The MCO will be at "risk" for the services listed in Contract Appendix A (Description of Covered and Excluded Services) through a capitation payment system. The MCO will be paid a fixed capitation rate PMPM and will not be permitted to collect any additional copayments or premiums from enrollees. Contract Appendix B (Overview of West Virginia's SFY 2024 Payment Methodology and Capitation Rates for Mountain Health Promise (MHP) contains a listing of the current capitation rates.

The MCO must provide covered services to Medicaid enrollees under this Contract in the same manner as those services are provided to other enrollees of the MCO, although delivery sites, covered services, and provider payment levels may vary. The MCO must guarantee that the locations of facilities and practitioners providing health care services to enrollees are sufficient in terms of geographic convenience to low-income areas, handicapped accessibility, and proximity to public transportation routes, where available.

The MCO is not required to provide, reimburse for, or provide coverage of counseling or referral services for which it has an objection on moral or religious grounds. The MCO must inform enrollees which services the MCO elects not to cover and provide instructions for how enrollees can obtain information from BMS about how to access those services. The MCO must notify enrollees when it adopts a policy to discontinue coverage of a counseling or referral service 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:

1. Provide annual notification to the parents, or custodian of the child, of screening due dates;
2. Provide outreach and education to providers, parents, and custodians on the importance of completing EPSDT screenings using HealthCheck screening questions and/or protocols;
3. Perform the screenings according to the State-determined periodicity schedule according to the age of the child;

4. Make the necessary and appropriate referrals for corrective treatment as determined by child health screenings immediately, with follow-up contact to ensure the enrollee receives a complete, appropriate evaluation;
5. Track referrals and treatments to:
    a. Ensure screening are completed for members; and
    b. Ensure that members with identified needs through the screening are linked to Medically Necessary services.
6. Record the results in the child's record and report to the State via the encounter reporting system; and
7. Report results as necessary to meet federal requirements, as requested by the Department.

The MCO must have written policies and procedures describing the MCO's responsibility for providing the full range of EPSDT services to all eligible children and young adults up to age twenty-one (21). This information must be available and accessible for the hearing- and visually-impaired. Translation services must be made available as necessary. The full scope of EPSDT service requirements is described below.

The MCO must, at a minimum, use the HealthCheck screening questions and encourage and educate contracted providers to use the HealthCheck screening forms and/or protocols. The MCO must also outreach to parents to encourage consistent participation in the EPSDT screenings and benefits. The MCO must ensure that providers answer the questions contained on the HealthCheck forms regardless of how their actual materials are formatted, so that such information can be recorded and reported to BMS with any other information required for the purposes of tracking EPSDT participation goals.

Based on BMS' CMS-416 MCO report, if BMS' overall rate falls below eighty percent (80%), BMS reserves the right to require the MCO to implement a PIP on EPSDT Screening and Community Outreach. MCOs shall implement the PIP required by BMS within ninety (90) days. The MCO shall use existing processes, methodologies, and protocols, including the CMS protocols.

2.2.3.2 Provide Information on EPSDT HealthCheck and Notification of Screening Due Dates

The MCO must provide a combination of written and oral methods designed to effectively inform all EPSDT-eligible individuals, their families, and their foster care parents, and CPS worker if applicable about the EPSDT program. The MCO must have an established process for ensuring all reminders, follow-ups, and outreach to enrollees are accessible and culturally competent for all enrollee populations.

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. In the case of families that have not utilized EPSDT services, the MCO must have processes in place to effectively inform eligible individuals on an annual basis. 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
9. Health education (including anticipatory guidance).

The MCO must also provide inter-periodic screenings, which are any encounters with a health professional practicing within the scope of his or her practice and who provides Medically Necessary health care, diagnosis, or treatment to determine the existence of a suspected illness or condition, or a change or complication to a pre-existing condition. The inter-periodic screen is used to determine if there is a problem that was not evident at the time of the regularly scheduled screen but needs to be addressed before the next scheduled screen.

2.2.3.4 Make the Necessary Referrals

In addition to any diagnostic and treatment services included in the defined EPSDT benefit package, the MCO must provide the following services to eligible enrollees, if the need for such services is indicated by screening:

1. Diagnosis of and treatment for defects in vision and hearing;
2. Dental care (at as early an age as necessary) needed for relief of pain and infections, restoration of teeth, and/or maintenance of dental health; and
3. Appropriate immunizations (if it is determined at the time of screening that immunization is needed and appropriate to provide at that time, then immunization treatment must be provided at the time of screening); and
4. Medically Necessary specialized treatment and/or behavioral health services.

The MCO should develop guidelines for review and processing of medical and behavioral health referrals resulting from EPSDT screening. The MCO must submit such guidelines to BMS for review and approval prior to use.

If a suspected problem is detected during an EPSDT HealthCheck screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

The MCO is financially responsible for providing such other necessary health care and all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered by the screening services. Medically necessary services must be contained within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, whether or not such services are covered under the State Plan.

Per 42 CFR §441.61(a), in the event a child needs a treatment that is not covered under the categories listed in Section 1905(a) of the Social Security Act, the MCO must provide referral assistance that includes giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family. The MCO must also connect the member and their family to their local community health and human service agencies either via a care manager or referral for additional resources and support to manage uncovered treatments.

The MCO is responsible for determining if covered services are Medically Necessary. The determination of whether a service is Medically Necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. Because medical 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).

2.2.4 Emergency Care

MCO policy and procedures, covered Medicaid services, claims adjudication methodology, and reimbursement performance for emergency care services must comply with all applicable state and federal laws, rules, and regulations, including 42 CFR §438.114, whether the provider is in the MCO's network or out-of-network. The MCO must cover and pay for all medical, behavioral, inpatient pharmacy, dental services, and emergency transportation described in Contract Appendix A that may be required on an emergency basis twenty-four (24) hours each day, seven (7) days a week, either in the MCO's facilities or through arrangements approved by

the Department.[2] The terms "Emergency Care," "Urgent Care," "Emergency Medical Conditions," and "Emergency Dental Condition" are defined in Article II of this Contract.

Reimbursement for emergency services provided in-network and out-of-network must be equal to the Medicaid prevailing FFS reimbursement level for emergency services, less any payments for direct costs of medical education and direct costs of graduate medical education included in the FFS reimbursement rate. In emergency situations, no pre-authorization is required to provide necessary medical care and enrollees may seek care from non-participating providers.

The MCO must reimburse for Medicaid emergency transportation at a rate of at least one-hundred percent (100%) of the Medicaid fee schedule for emergency ground transportation and emergency air transportation.

Upon BMS notification to the MCO of any changes to the emergency transportation reimbursement rates, the MCO must update payment rates to emergency transportation providers to the effective date in the notification by BMS. If payment was already made for a claim within the current SFY with a date of service on or after the effective date of the rate change, the MCO must reprocess the claim to reimburse at the new rate. Claims reprocessing at the new rate includes those claims with dates of service in a prior SFY if the payment had been made in the current SFY. The new payment rate must be loaded into the MCO's claims payment system within thirty (30) calendar days of notification of the payment rate change.

The MCO is required to inform enrollees or their representatives regarding their rights of access to and coverage of emergency services, both inside and outside of the plan's network.

Coverage of emergency services by the MCO will be determined under the "prudent layperson" standard. That standard considers the symptoms (including severe pain) of the presenting enrollee. The MCO may not limit what constitutes an Emergency Medical or Behavioral Health Condition on the basis of lists of diagnoses or symptoms.

The MCO may not deny payment for treatment obtained when an enrollee had an emergency medical or dental condition in which the absence of immediate medical attention would have placed the health of the individual, or in the case of a pregnant women, the woman or her unborn child, in serious jeopardy; resulted in serious impairment to bodily functions; or resulted in serious dysfunction of any bodily organ or part. The MCO may not deny payment for treatment when a representative of the MCO instructs the enrollee to seek emergency care.

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.

---

[2] Qualified medical personnel must be accessible twenty-four (24) hours each day, seven (7) days a week, to provide direction to patients in need of urgent or emergency care. Such medical personnel include, but are not limited to, physicians, physicians on-call, licensed practical nurses, or registered nurses.

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 with care of the patient until the MCO physician is reached or one of the criteria in §422.113(c)(3) is met.

Post-stabilization services are not "emergency services," which the MCO is obligated to cover in-or-out of plan according to the "prudent layperson" standard. Rather, they are non-emergency services that the MCO could choose not to cover out-of-plan except in the circumstances described above.

The intent of this provision is to promote efficient and timely coordination of appropriate care of a managed care enrollee after the enrollee's condition has been determined to be stable.

The MCO is required to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCO would charge the enrollee if he or she obtained the services through the MCO.

The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A MCO physician with privileges at the treating hospital assumes responsibility for the enrollee's care; or
- A MCO representative and the treating physician each reach an agreement concerning the enrollee's care.

2.2.6 Family Planning

In accordance with 42 CFR §438.206(b)(7), the MCO must ensure that its network includes sufficient family planning providers to ensure timely access to covered family planning services for enrollees. Although family planning services are included within the MCO's list of covered benefits, Medicaid enrollees are entitled to obtain all Medicaid covered family planning services without prior authorization through any Medicaid provider, who will bill the MCO and be paid on a FFS basis.[3]

The MCO must give each enrollee, including adolescents, the opportunity to use his/her own PCP or go to any family planning center for family planning services without requiring a referral. The MCO must make a reasonable effort to Subcontract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act, and must reimburse providers for all family planning services regardless of whether they are rendered by a participating or non-participating provider. Unless otherwise negotiated, the MCO must reimburse providers of family planning services at the Medicaid rate. The MCO may, however, at its discretion, impose a withhold on a contracted PCP for such family planning services. The MCO may require family planning providers to submit claims or reports in specified formats before reimbursing services.

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

---

[3] Access to family planning services without prior notification is a federal law. Under OBRA 1987 Section 4113(c)(1)(B), "enrollment of an individual eligible for medical assistance in a primary case management system, a health maintenance organization or a similar entity must not restrict the choice of the qualified person, from whom the individual may receive services under Section 1905(a)(4)(c)." Therefore, Medicaid enrollees must be allowed freedom of choice of family planning providers and may receive such services from any family planning provider, including those outside the MCO's provider network, without prior authorization.

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.

Non-participating providers are responsible for keeping family planning information confidential in favor of the individual patient even if the patient is a minor. The MCO is not responsible for the confidentiality of medical records maintained by non-participating providers.

2.2.6.2 Tubal Ligation

In accordance with West Virginia Code § 9-5-12(d), the Department shall make payment for tubal ligation without requiring at least thirty (30) days between the date of informed consent and the date of the tubal ligation procedure. Tubal ligation services for which the MCO is not responsible for payment are excluded from the MCO's capitation rates but will remain covered Medicaid services for persons who are enrolled in the MCO. The Department shall pay claims

for tubal ligation on a FFS basis in accordance with West Virginia Department of Human Services, Bureau for Medical Services Policy 519.15, Women's Health Services.

The MCO must provide coverage and payment for tubal ligation services that do not fall into the category of those described above for which DoHS will pay on a FFS basis. Such coverage and payment shall be in accordance with West Virginia Department of Human Services, Bureau for Medical Services Policy 519.15, Women's Health Services. Claims for tubal ligation services must include the modifier (-FP), and providers must maintain a copy of the signed informed consent form in the enrollee's medical record.

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.

2.2.7 Maternity Services

Under the Newborns and Mothers Health Protection Act, the MCO may not:

- Limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time; or
- Require that a provider obtain authorization from the plan before prescribing this length of stay.

This requirement must not preclude the MCO from requiring prior authorization or denying coverage for elective inductions and elective cesarean sections.

2.2.8 Vaccines for Adults

In accordance with Section 11405 of the Inflation Reduction Act (Pub. L. 117-169), the MCO must provide coverage and payment of approved adult vaccines and their administration.

2.2.9 Cell and Gene Therapy (CGT) Access Model

BMS is implementing the Cell and Gene Therapy (CGT) Access Model that aims to improve the lives of Medicaid enrollees living with rare and severe diseases by increasing access to potentially transformative treatments. At the time of implementation, BMS will cover the cost of gene therapies, a FFS benefit, and the MCO must provide for the following:

- Provide coverage for inpatient stay and follow-up care in a qualified in-state or out-of-state facility.
- Communicate treatment options to eligible enrollees.
- Meet provider network requirements as outlined in Article III, Section 2.3 of this Contract.
- Meet all reporting requirements as directed by BMS.

2.2.10 Justice-Involved Enrollees

BMS and the MCO must comply with Section 5121 of the Consolidated Appropriations Act of 2023 to provide supports and services for justice-involved youth. At such time that BMS determines services will be implemented, the MCO must provide for services for enrollees and comply with all programmatic and reporting requirements. Upon request, the MCO must collaborate with BMS in planning for and implementation of these services.

2.3 Medicaid Benefits Covered but Excluded from Capitation that Require Coordination

Additional services are covered by Medicaid, but excluded from the MCOs' capitation rates. The State will continue to reimburse the billing provider directly for these services on a FFS basis. Please see Appendix A for a complete list of Medicaid-covered services that are excluded from the capitation rates, and additional details regarding these services.

Those Medicaid-covered services that are excluded from the capitation rates (e.g., non-emergency transportation) have particular coordination requirements for MCOs, which are outlined below.

2.3.1 Non-emergency Transportation

Routine medical transportation to and from Medicaid-covered scheduled medical appointments is covered by the non-emergency medical transportation (NEMT) broker Medicaid program. This includes transportation via multi-passenger van services and common carriers such as 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.
3. Fraud and abuse identification: The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

2.3.3 Organ and Tissue Transplantations

MCO enrollees receiving services for transplantation of organs or tissues, other than corneal transplants, are covered under FFS Medicaid for the entire duration of their treatment. Additionally, MCO enrollees who, as living donors, provide organs or tissues for transplantation, other than corneal transplants, will receive services for such transplantation and be covered under FFS Medicaid for the entire duration of their treatment.

The MCO must have the ability to notify the State of any past, present, or future transplant recipient or living donor and request transfer to FFS Medicaid. The Department will coordinate with Utilization Management vendor and MMIS vendor to transition enrollees to the FFS system and coordinate care at that time. The enrollee will be covered under FFS retroactively to the beginning of the month that the MCO notifies the State. Capitation will be recouped for this month. Any claims paid during the month by the MCO may be reversed and directed to the fiscal agent for payment.

2.4 In Lieu of Services and Settings

BMS is planning for implementation of In Lieu of Services and Settings (ILOS) that will be allowable substitutions for services or settings covered under the State Plan or otherwise covered by this Contract. The MCO shall collaborate with BMS, other MCOs, and other BMS vendors as necessary throughout the planning process. BMS will amend this Contract to incorporate the approved ILOS that MCOs may opt to offer to enrollees in accordance with 42 C.F.R. §438.

At such time as implemented, the MCO may cover for enrollees, services or settings that are In Lieu of Services or settings covered under the State Plan. Contract provisions between BMS and the MCO will address, but not be limited to, the following federal regulations set forth at 42 C.F.R. 438.3(e)(2) that allow for MCOs to cover ILOS:

1. The ILOS is a medically appropriate and cost effective substitute for the covered service or setting under the State Plan;

2. Enrollees are not required to use the ILOS, they retain all rights and protections afforded under 42 C.F.R. 438, and when choosing not to receive an ILOS they retain rights to receive the services or settings covered under the State Plan on the same terms as would apply if an ILOS was not an option;

3. The ILOS may not be used to reduce, discourage, or jeopardize an enrollee's access to services and settings covered under the State Plan, and the MCO may not deny access to a service or setting covered under the State Plan on the basis that the Enrollee has been offered an ILOS as an optional substitute for a service or setting covered under the State Plan, is currently receiving an ILOS as a substitute for a service or setting covered under the State Plan, or has utilized an ILOS in the past;

4. The utilization and actual cost of the ILOS is taken into account in developing the component of the capitation rates that represents the covered State Plan services and settings, unless a statute or regulation explicitly requires otherwise; and

5. With the exception of a short term stay as specified in 42 C.F.R. 438.6(e) in an Institution for Mental Diseases (IMD), as defined in 42 C.F.R. 435.1010 for inpatient mental health or substance use disorder treatment, an ILOS must also comply with the requirements in 42 C.F.R. §438.16.

2.5 Non-covered Services

The MCO is not permitted to provide Medicaid excluded services that include, but are not limited to, the following:

1. All non-medically necessary services*;
2. Sterilization of a mentally incompetent or institutionalized individual;
3. Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition;
4. All organ transplants, except for those specified in Appendix A;
5. Treatments for infertility[4] and for the reversal of sterilization;
6. All cosmetic services, except for those provided as a result of accidents or birth defects; and

[4] Infertility services are excluded per West Virginia State law, section 33-25A-4(2)(b).

7. Christian Science nurses and sanitariums.

**The above language is not inclusive of children's residential treatment services which is covered using a bundled funding model of Medicaid and ACF funds.*

The MCO must not reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the Department's Outpatient Drug Pharmacy Program.

In accordance with 42 U.S.C. § 1396r-8, the MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. The MCO is not permitted to provide coverage for any drug product, brand name or generic, legend 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.

2.6 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.

---

[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.

2.7 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 under the MHP program.

2.7.1 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.

2.7.2 Multidisciplinary Teams (MDT)

An MDT works together with the child in foster care and the child's family to develop a case service plan and coordinate services. It is the central point for decision making during the life of a case. The MCO must participate in the MDT process at the request of the CPS worker, judge, or the MDT itself. The MCO need not participate in every MDT, but is expected to serve as a resource to caseworkers to help in facilitating the process if needed, to ensure the enrollee is receiving the most appropriate, effective treatment options.

3. PROVIDER NETWORK

3.1 General Requirements

3.1.1 Network Capable of Full Array of Services

In accordance with 42 CFR §438.206(b)(1), the MCO must establish and maintain provider networks in geographically accessible locations for the populations to be served. These networks must be comprised of hospitals, PCPs, dental providers, mental health and substance use disorder providers, specialty care providers, residential treatment providers, and BSS approved non-traditional providers who provide SNS in sufficient numbers to make available all covered services as required by the availability and access standards of the contract. In accordance with 42 DFR §438.207, the MCO must maintain a sufficient number, mix, and geographic distribution of providers.

To the extent possible and in accordance with Article III, Section 5.11, the MCO must promote the use of telehealth/ telemedicine to support an adequate provider network and expand the use and availability of telehealth/telemedicine when indicated and appropriate to help ensure geographic accessibility to its enrollees.

The MCO must contract with sufficient numbers of providers to maintain sufficient access in accordance with the Department's Medicaid managed care network standards and SNS provider network standards for all enrollees, including those with limited English proficiency or physical or mental disabilities.

The Provider network must include the following:

- Primary care and specialist providers who are trained or experienced in trauma-informed approaches to care and in treating individuals with complex special needs, including the entire population that comprises the enrollees covered under this Contract; and
- Providers who have knowledge and experience in identifying child abuse and neglect.

The MCO must submit to the Department written documentation of the adequacy of its provider network as set forth in this Contract at the following times:

- When the MCO enters into a Contract with the Department;
- On an annual basis;
- When there has been a significant change in MCO operations;
- When services, benefits, geographic service areas, or payments have been changed; or
- When there is enrollment of a new population in the MCO.

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 J. They include standards for:

- PCPs;
- Specialists;
- Obstetricians/gynecologists (OB/GYNs);
- Basic hospital services;
- Tertiary hospital services[6];
- Pediatric dental providers;
- Behavioral health providers and facilities;
- Substance use disorder (SUD) providers and facilities;
- PRTFs; and
- Additional providers when it promotes the objectives of the Medicaid program as determined by CMS.

The intent of these standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program. The Department will periodically publish specific network standards that define which provider types are considered adult and pediatric specialists. The MCO will be required to comply with updated network standards within ninety (90) calendar days of issuance, unless otherwise agreed to in writing by the Department within sixty (60) calendar days of issuance.

During any period in which the MCO does not meet minimum network standards, the MCO must ensure that appropriate processes are implemented to adequately cover services in a timely manner out-of-network, including paying claims to out-of-network providers and ensuring that enrollees incur no additional costs, as specified in 42 CFR §438.206(b) and §457.1230(a).

3.1.2.1 Exceptions to Network Standards

The Department will consider requests for exceptions to the provider access standards under limited circumstances (e.g. if no appropriate provider types are located within the mileage standards) and may, in its sole discretion, grant exceptions to these standards. Each exception request from the MCO to the Department must be in writing and supported by information and documentation from the MCO. Exceptions to network requirements will be considered based on

---

[6] 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.

the information provided, current patterns of care, and locations where the travel time and distance standards differ significantly from providers in the community.

The State will grant exceptions to the MCO based on additional documentation from the MCO that a provider may be seen out-of-network in the event a contracted provider arrangement cannot be obtained. Exceptions are monitored closely and typically only granted in instances where a provider does not exist within a specific geographic location and a provider in an urban area must be leveraged; these exceptions will be applied consistently across all MCOs. The State will provide each MCO with all other MCO provider files to identify potential providers in service gap areas to help address any potential deficiencies to avoid the exemption process.

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);
- EPSDT services must be scheduled in accordance with EPSDT guidelines and the EPSDT Periodicity Schedule;
- The MCO shall identify pregnant individuals at enrollment and on an ongoing basis. An initial prenatal care visit must be scheduled within fourteen (14) calendar days of the date on which the woman is found to be pregnant; and
- The MCO must encourage enrollees with Supplemental Security Income (SSI) to schedule an appointment with a PCP or specialist who manages the enrollee's care within forty-five (45) calendar days of initial enrollment. If requested by the enrollee or provider, the MCO must schedule or facilitate an appointment with the enrollee's PCP.

3.1.3 Specialty Care

The MCO must provide or arrange for necessary specialty care, including behavioral health services, SUD services, women's health services, and CSED services (if applicable). In accordance with 42 CFR §438.206(b)(2), the MCO must allow women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services, in addition to direct access to a PCP for routine services, if the PCP is not a women's health specialist. The MCO must have a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan.

3.1.4 Provider Qualification and Selection

The MCO must implement written policies and procedures for selection and retention of affiliated providers. If such functions are delegated, credentialing and recredentialing policies and procedures must meet the requirements of this section. In contracting with its providers, the MCO must abide by all applicable federal regulations including but not limited to W. Va. C.S.R. §114-53-6 and 42 CFR §438.610 and 42 CFR §455, Subpart B.

For physicians and other licensed health care professionals, including members of physician groups, the process includes:

- Procedures for initial credentialing;
- Procedures for recredentialing at least every three (3) years, recertifying, and/or reappointment of providers;
- A process for receiving advice from contracting health care professionals with respect to criteria for credentialing and recredentialing of individual health care professionals; and

- Written policies and procedures for denying, suspending, or terminating affiliation with a contracting health care professional, including an appeals process, and for reporting serious quality deficiencies to appropriate authorities.

Upon receipt of an individual provider's initial credentialing or re-credentialing application, the MCO must make a determination on that application within ninety (90) calendar days for credentialing and sixty (60) calendar days for recredentialing. The MCO must make a determination on a provider's clean application within this timeframe unless the MCO identifies a substantive quality or safety concern in the course of provider credentialing or recredentialing that requires further investigation. Upon notice to the individual provider, clinic, or facility, the 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 §438.602(b). Enrollment with the Department does not obligate the MCO provider to offer services under the FFS delivery system. The MCO is not required to contract with a provider enrolled with the Department that does not meet their credentialing or other requirements.

As part of the provider enrollment process, the fiscal agent, on behalf of the Department, will perform monthly federal databases checks as required by 42 CFR §455.436 and share results with the MCO. The MCO must collaborate with the fiscal agent to ensure compliance of all entities per Article II, Section 8.7.

The MCO may execute a provider agreement, pending the outcome of this screening, enrollment, and revalidation, for up to one hundred twenty (120) days. However, the MCO must terminate the network provider immediately upon notification from the state that the network provider cannot be enrolled, or if the one hundred twenty (120) day period expired without state enrollment of the provider. Upon termination of the provider from the MCO's network, the MCO must notify all affected enrollees.

3.1.5 Credentialing and Recredentialing Criteria

The credentialing process must comply with West Virginia C.S.R. §114-53-6 and 42 CFR §455, Subpart B and at a minimum include a statement by the applicant regarding:

- Any physical or mental health problems that may affect current ability to provide health care;
- Any history of chemical dependency/SUD;
- History of loss of license;
- Felony convictions as required by West Virginia C.S.R. §114-53-6.3 and other criminal convictions as required by 42 CFR §455.106;
- History of loss or limitation of privileges or disciplinary activity;
- History of debarment, suspension, or exclusion from any Federal or State healthcare programs; and
- An attestation to correctness/completeness of the application.

During the initial credentialing process, the MCO must verify:

- The identity and the exclusion status of provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of Federal databases as described in 42 CFR §455.436;
- The provider holds a current valid license to practice;

- Valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate, as applicable;
- Graduation from medical school and completion of a residency, or other post-graduate training, as applicable;
- Board certification or eligibility, or specialized training as appropriate;
- Work history;
- 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.

3.1.6.2 Credentialing and Recredentialing Criteria for Dental Providers

Additional credentialing and recredentialing criteria for dental providers must include: Anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners for those dental providers who induce central nervous system anesthesia.

3.1.6.3 Credentialing and Recredentialing Criteria for Behavioral Health Care Providers and Agencies

Additional credentialing and recredentialing criteria for behavioral health care providers and agencies must include:

- The MCO must verify that a Comprehensive Behavioral Health Center or a Licensed Behavioral Health Center holds a valid license through the West Virginia Office of Health Facility Licensure and Certification; and
- The MCO must verify that an independent psychologist or an independent practicing licensed social worker holds current license with their professional boards.

3.1.7 Provider Education and Training

The Contractor must provide training to all contracted providers and their staff regarding the requirements of the Contract and special needs of its enrollees. The Contractor must conduct initial training within thirty (30) calendar days of executing a contract with a newly contracted provider. The Contractor must also conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Contractor or the Department in order to ensure compliance with program standards and this Contract and meet the needs of providers.

The provider education and training must include, at a minimum:

- The roles and responsibilities of the provider, the Department, BSS, local CPS workers, enrollees, foster care parents, and adoptive parents with regard to the program and how these partners will coordinate services with the Contractor;
- Covered medical, behavioral, CSED waiver and SNS services and the provider's responsibilities for providing and/or coordinating such services. A special emphasis must be placed on areas that vary from MHT and WVHB Medicaid coverage and commercial coverage rules;
- Requirements for providing services to enrollees, including medical consent requirements, required timelines for services and assessments, special medical 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 must allow the enrollee the opportunity to select a new PCP before being assigned one. The MCO must have procedures to address changes in its network that constrain the ability of clients to access services. The Contractor must notify the Department within seven (7) business days of any significant changes to the provider network or, if applicable, to any subcontractors' provider networks. Material changes in network composition that negatively affect client access to services and which are not corrected may be grounds for Contract termination.

3.2 Primary Care Providers (PCPs)

3.2.1 PCP Responsibilities

The PCP will be the MCO enrollee's initial and most important contact with the MCO. As such, PCPs must have at least the following responsibilities:

- Maintaining continuity of each enrollee's health care by serving as the enrollee's PCP;
- Providing twenty-four (24) hour, seven (7)-day-a-week access;
- Making referrals for specialty care and other Medically Necessary covered services, both in-network and out-of-network, consistent with the MCO's utilization management policies;
- Maintaining a current medical record for the enrollee, including documentation of all services provided to the enrollee by the PCP, as well as any specialty or referral services;
- Adhering to the EPSDT Periodicity Schedule for enrollees under age twenty-one (21); and
- Following MCO-established procedures for coordination of in-network and out-of-network services for Medicaid enrollees.

Although PCPs must be given responsibility for the above activities, the MCO must also retain responsibility for monitoring PCP actions to ensure they comply with MCO and West Virginia Medicaid managed care program policies.

Additionally, the MCO must communicate with PCPs about the delivery of primary behavioral health services within their scope of practice, as well as the appropriate circumstances for making referrals to behavioral health providers. MCOs may provide this information through its provider manual, continuing education agendas, informal visits by provider representatives, or any other means. The MCO must ensure that PCPs are successfully identifying and referring patients to a behavioral health provider and provide education to PCPs who do not have training in this area.

3.2.2 Ratio of PCPs to Enrollees

The MCO's provider network must include a panel of PCPs from which the enrollee may select a personal PCP. The MCO must maintain an adequate panel of available PCPs so that the ratio of PCPs to enrollees meets or exceeds the required ratio of one (1) PCP for every five hundred (500) adult enrollees who is accepting enrollees and one (1) age appropriate PCP for every two hundred fifty (250) pediatric enrollees under twenty-one (21) who is accepting patients as outlined in Appendix J.

Only PCPs who have assigned MCO enrollees and are listed in the MCO's provider directory as accepting new patients will count toward the provider-to-enrollee ratio. Specialists designated as 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:

- Certified nurse midwives[7];
- Advanced practice nurses (e.g., nurse practitioners (NP)[8]);

---

[7] Certified nurse midwives are required to practice in a collaborative relationship with a licensed physician (West Virginia Code §30-15-7). The MCO must ensure compliance with all relevant federal and state regulations related to certified nurse midwives.

[8] Nurse practitioners with prescriptive authority must practice in a collaborative relationship with a licensed physician (West Virginia Code §30-7-15a). The MCO must ensure compliance with all relevant federal and state regulations related to nurse practitioners.

- Physician assistants; and
- Physicians with the following specialties: General practice; Family practice; Internal medicine; Obstetrics/Gynecology; and Pediatrics.

The MCO will be allowed to designate physicians outside of these specialties as PCPs for specific individuals including those within the disabled population whose underlying health conditions are best managed by specialists. The MCO must outreach to such specialists to provide information about responsibilities for EPSDT services, as set forth in Article III, Section 2.2.3.

The MCO must permit any certified nurse midwife, advanced practice nurse or PA, who is otherwise permitted within the scope of their practice, and who is a Medicaid enrolled provider, to be designated a PCP for an enrollee and bill independently.

3.2.5 PCP Team in Teaching Settings

If the MCO's primary care network includes institutions with teaching programs, PCP teams, comprised of residents, physicians' assistants and a supervising faculty physician, may serve as a PCP. The MCO must organize its PCP teams to ensure continuity of care for enrollees and must identify a lead physician within the team for each enrollee. The lead physician must be an attending physician and not a resident.

3.2.6 PCP Transfers

The MCO must have written policies and procedures for allowing Medicaid enrollees to select or be assigned to a new PCP when such a change is requested by the enrollee, when a PCP is terminated from the MCO, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, the MCO must allow affected enrollees to select other PCPs or make a reassignment within fifteen (15) calendar days of the termination effective date.

Enrollees may initiate a PCP change at any time, for any reason. The request can be made in writing or over the phone. The MCO is permitted to limit PCP changes to one time per month. The MCO may initiate a PCP change for a Medicaid enrollee under the following circumstances:

1. The enrollee moves or there is a change in the placement of a child in foster care and the assigned PCP location no longer meets the access standards;
2. The enrollee requires specialized care for an acute or chronic condition, and the enrollee and MCO agree that reassignment to a different PCP is in the enrollee's interest;
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, etc. that are accessible to enrollees for non-emergency and emergency needs. The MCO must ensure all laboratory testing sites providing services under this contract have either a clinical laboratory (CLIA) certificate or a waiver of a certificate of registration, along with a CLIA number, pursuant to 42 CFR 493.3. See Appendix J, Provider Network Standards, Network Adequacy for Additional Provider Types.

The MCO must maintain a contract with at least one (1) in-state provider and one out of state preferred children's hospital as directed by BMS that is qualified to administer a gene therapy for sickle cell disease.

---

[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.

3.4 Publicly Supported Providers

3.4.1 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Federally Qualified Health Centers (FQHCs) are federally-funded Community Health Centers, Migrant Health Centers and Health Care for the Homeless Projects that receive grants under sections 329, 330 and 340 of the US Public Health Service Act.[10] Current federal regulations specify that states must guarantee access to FQHCs and Rural Health Clinics (RHCs) under Medicaid managed care programs; therefore, the MCO must provide access to FQHCs and RHCs to the extent that access is required under federal law. If federal law is amended to revise these access requirements, the Department may alter the requirements imposed on the MCO.

The MCO must contract with as many FQHCs and RHCs as necessary to permit beneficiary access to participating FQHCs and RHCs without having to travel a significantly greater distance past a non-participating FQHC or RHC. The MCO must Contract with the FQHC or RHC – contracts with individual physicians at FQHCs and RHCs do not suffice for this requirement. The MCO must contract with FQHCs and RHCs in accordance with the time and distance standards for routinely-used delivery sites as specified in this contract in Appendix J. An MCO with an FQHC or RHC on its panel that has no capacity to accept new patients will not satisfy these requirements. If an MCO cannot satisfy the standard for FQHC and RHC access at any time while the MCO holds a Medicaid contract, the MCO must allow its Medicaid enrollees to seek care from non-contracting FQHCs and RHCs and must reimburse these providers at Medicaid fees.

In accordance with BMS policy, reimbursement rates for FQHCs/RHCs may be adjusted based on events approved by BMS. Actuarially sound capitation rates will be developed to consider MCO liabilities for changes in FQHC/RHC reimbursement rates. BMS is not responsible for any payments to FQHCs/RHCs resulting from changes in reimbursement rates. Upon BMS notification of FQHC/RHC reimbursement rate changes, the MCO must update its claims payment system within thirty (30) calendar days. FQHC/RHC reimbursement rate changes must be set to the effective date indicated in the notification from BMS. The MCO is responsible for reversing and re-processing payments to FQHCs/RHCs based on changes in reimbursement rates. Changes in FQHC/RHCs reimbursement rates and re-processing should be reported on the MLR in the period in which they are paid.

3.4.2 Local Health Departments

Local governmental departments administer certain public health programs which are critical to the protection of the public's health and, therefore, must be available to Medicaid managed care 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

---

[10] Health centers not receiving grants but certified by the Secretary of Health and Human Services as meeting the requirements of the grant program may also apply for FQHC status as an FQHC "look-alike." All FQHCs are non-profit or public entities and must be located in areas designated by the federal government as medically underserved.

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 information between the SBHCs and the MCO, and provide for reimbursement of the SBHC by the MCO.

The MCO is encouraged, but not required, to contract with SBHCs.

3.4.6 Right from the Start (RFTS) Providers

Right from the Start (RFTS) is a West Virginia State program aimed at improving early access to prenatal care and lowering infant mortality, and improved pregnancy outcomes. The RFTS eligibility criteria and services provided are available from the Department. The MCO is encouraged, but not required, to contract with RFTS providers. However, if the MCO does not contract with RFTS providers, the MCO must provide the same level and types of services as those currently available through the RFTS program. This includes access to multidisciplinary care. The Department will monitor compliance with this requirement; if the MCO fails to satisfy these requirements, it will be required to reimburse the traditional RFTS providers at the Medicaid fee rate. The MCO may not place prior authorization requirements on RFTS services.

3.4.7 Bureau for Public Health Laboratories

The MCO is required by law to use Bureau for Public Health Laboratories for certain cases (e.g., metabolic testing for newborns, rabies), and the Bureau for Public Health Laboratories is required to perform tests, including those mentioned under core services above, on MCO enrollees for public health purposes. In addition, all laboratories contracted by the MCO that have positive findings of certain reportable diseases under the Reportable Disease Rule in category I, II and IV (the list of reportable diseases is available from the Department of Health) must submit an isolate, serum specimen or other designated material to the Office of Laboratory Services (OLS) for confirmation or other testing needed for epidemiological surveillance. These services are usually funded by state or federal funds; however, whenever a service is not funded by other state or federal funds, the MCO must reimburse OLS for these services.

3.4.8 Children with Special Health Care Needs Program (CSHCN) Providers

The Children with Special Health Care Needs (CSHCN) Program provides care coordination and access to specialty services through a system of community-based Care Coordinators[11] and specialty clinics, thus enabling children and youth with special health care needs to receive a patient/family-centered medical home approach to comprehensive, coordinated services and supports.

The MCO is encouraged, but not required, to contract with CSHCN providers. However, if the MCO does not contract with CSHCN providers, the MCO must provide the same level and types of services as those currently available through the CSHCN program. This includes access to multidisciplinary care. The CSHCN eligibility criteria and services are available from the Department. The Department will monitor compliance with this requirement; if the MCO fails to satisfy these requirements, it will be required to reimburse the traditional CSHCN providers at the Medicaid fee rate.

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.

---

[11] Registered Nurses and Licensed Social Workers that, on behalf of medical homes of children and youth with special heath care needs, facilitate the patient and family engagement necessary for coordinated, ongoing, comprehensive care.

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
7. Educating providers about the MCO's written policies on the False Claims Act, including policies and procedures for detecting and preventing FWA. This requirement is pursuant to the Deficit Reduction Act of 2005, Section 6032.

The MCO must track and report all provider complaints regardless of their origin, communication method, or how they were received by the MCO. The MCO shall report this

information to BMS or its designated contractor on a quarterly basis via a reporting template provided by BMS.

3.6.1.2 Performance Requirements of the Toll-Free Provider Phone Line

The MCO must meet requirements in CFR 42 §438.10(d)(2) and §438.71(a). The MCO must ensure that the toll-free provider phone line meets the following minimum Service Level Agreements (SLAs):

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

The MCO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with operating hours, information and instructions on how to verify enrollment for an enrollee with an Urgent Condition or an Emergency Medical Condition.

If the MCO's Subcontractor operates a separate call center, the Subcontractor's call center must at a minimum meet the provider phone line performance standards set forth in this section and in Appendix F.

3.6.2 Provider Manual

The MCO must develop, distribute and maintain a provider manual. The MCO must submit a copy of the provider manual to the Department as part of the MCO's initial readiness review during implementation and annually by July 1st of each Contract year. BMS reserves the right to review and approve the MCO's provider manual. In addition, the MCO must document the approval of the provider manual by the MCO Administrator and Medical Director and must maintain documentation that verifies that the provider manual is reviewed at least annually. The MCO must ensure that each provider (individual or group which submits claim and encounter data) is issued a printed or electronic copy of the provider manual during the contracting process with the MCO. The MCO must provide a copy of the provider manual to a provider upon request. When there are Department policy or program changes or MCO procedure or service site changes, notification must be sent to the affected providers at least thirty (30) calendar days before the intended effective date of the change. The MCO must publish and keep current its provider manual on the MCO website as specified in Article III, Section 4.4.5 of this contract.

3.6.3 Provider Contract

The MCO's provider contracts and addenda to provider contracts must abide by all federal regulations and must be consistent with the requirements of this statement of work. The MCO must also comply with the prohibitions on inappropriate provider incentives as specified in Article III, Section 3.8 of this contract.

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 disclosure forms must request tax ID of any provider's Subcontractor in which the provider (if entity) has a five percent (5%) or more interest. The MCO provider contracts must request the name of each entity in which the provider's persons with ownership and control interest have an ownership or control interest. The provider must agree to keep

information current at all times by informing the MCO in writing within thirty-five (35) calendar days of any ownership and control changes to the information contained in its application;

7. Requirements for provider disclosure of significant business transactions, in accordance with 42 CFR §455.105. MCO provider contracts must include language specifying that the contracted provider is required 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 provider has had business transactions totaling more than $25,000 during the previous 12-month period and (2) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any Subcontractor, during the previous five years;

8. Requirements for provider disclosure of health-care related criminal convictions, in accordance with 42 CFR §455.106. The provider contracts or disclosure forms must request the provider, 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 to disclose information on criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The contracts must require a provider to notify the MCO immediately of the time the provider receives notice of such conviction. The MCO must include the definition of "Convicted" per 42 CFR §1001.2 in the Contract or disclosure form;

9. Requirements to terminate any providers of services or persons terminated (as described in section 1902(kk)(8) of the Social Security Act) from participation under this title, title XVIII, or title XXI from participating as a provider in any network;

10. Requirements for providers to report to the MCO PPCs associated with claims;

11. Certification that the provider, provider's director, officer, principal, partner, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider have not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal agreement. Certification that persons listed above have also not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any other state or federal health-care program. Requirement for a provider to notify the MCO immediately of the time it receives notice that any action is being taken against a provider or any person above as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. A provider must agree to fully comply at all times with the requirements of 34 CFR Part 76, relating to eligibility for federal agreements and grants;

12. Requirements for access to provider records. The provider contracts must include a provision requiring MCO providers to provide to the Department: 1. all information required under the MCO's managed care Contract with the Department, including but not limited to the reporting requirements and other information related to the network 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;

13. 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;
14. 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; and
    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.
15. 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;
16. 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;
17. Requirement for provider to comply with 42 CFR §422.128 and West Virginia Health Care Decisions Act relating to advance directives;
18. 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;
19. Language to prohibit providers from collecting copays for missed appointments;
20. Requirement for emergency care providers to educate the enrollee of the amount of his or her copay for non-emergency services provided in the emergency department prior to providing non-emergency services. The emergency services provider must be required to

provide an enrollee with the name and location of an available and accessible alternative non-emergency services provider;

21. Requirement for provider reporting and return of overpayments as outlined in Article III, Section 9.3;
22. Notice to the provider of the State's right to collect MCO overpayments directly from the provider pursuant to the MCO's assignment of rights to the Department, as described in Article III, Section 9.3 of the contract between the MCO and the State;
23. Notice to the provider that in the event the State collects overpayments directly from the provider, the provider's appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website;
24. Contracts with PCPs must also include a requirement that the provider have twenty-four (24)-hour PCP coverage;
25. Language encouraging providers to use the HealthCheck screening forms and/or protocols for eligible members;
26. The provider contract must identify the specific requirements of the provider in meeting compliance standards for the State's CSED waiver. Only those contracts with CSED providers need to make reference to these standards, as defined within the CSED Waiver Incident Reporting Guide, CSED Waiver, and CSED Policy Chapter 502; and
27. For CSED waiver provider contracts, the MCO shall include reference to the Person-Centered Service Plan requirement of the provider for submission to the MCO.

3.6.4 Provider Information Systems Support

The MCO must work with providers to establish electronic billing, authorization and reporting systems that are compatible with provider electronic health record (EHR) systems. The MCO's hardware, software, and communications must be capable of accommodating individual provider information systems. Such accommodations may not be in violation any requirements promulgated pursuant to HIPAA (August 21, 1996), as amended or modified, HITECH, and other applicable federal and state laws.

3.6.5 Provider Satisfaction Survey

The MCO is required to design, develop, and implement an annual provider satisfaction survey to evaluate provider or provider staff satisfaction with the MCO.

3.6.6 Secure Provider Portal

The MCO must have a secure portal that allows providers to request prior authorization for services, and review claims status. The portal must comply with all requirements of West Virginia Code § 9-5-32.

The MCO must collect, analyze, and submit provider survey results to the Department on an annual basis. The survey must be submitted prior to the conclusion of the contracting period of each Contract year, June 30th.

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:

1. Services were rendered to treat a Medical Emergency;
2. Services were for family planning and STDs;
3. Services were prior authorized; or
4. Retro-authorization meeting medical necessity has been granted due to the nature of service.

For non-emergency out-of-network services, the MCO may reimburse providers at eighty (80) percent of the prevailing Medicaid FFS rate or higher, unless such services are deemed medically unnecessary, are not covered by the MCO, or do not receive authorization.

Consistent with Article III, Section 2.2.2, reimbursement for emergency services provided out-of-network must be equal to the Medicaid prevailing FFS reimbursement level for emergency services, less any payments for direct costs of medical education and direct costs of graduate medical education included in the FFS reimbursement rate.

3.7.4 Out-of-Network Hospital Transfers

The MCO must pay an enrollee's existing out-of-network hospital fees for Medically Necessary covered emergency services until the enrollee's records, clinical information and care can be transferred to a network hospital, or until such time as the enrollee is no longer enrolled in that MCO, whichever is shorter. The MCO must accept the out-of-network hospital physician or provider's binding determination of when the enrollee is sufficiently stabilized for transfer or discharge.

3.7.5 Emergency Services

When emergency services are provided to an enrollee of the MCO, the MCO's liability for payment is determined as follows:

1. **Presence of a Clinical Emergency:** If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the MCO must pay for both the services involved in the screening examination and the services required to stabilize the patient.
2. **Emergency Services Continue Until the Patient Can be Safely Discharged or Transferred:** The MCO is required to pay for all emergency services which are Medically Necessary until the clinical emergency is stabilized. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility. If a hospital and the MCO disagree as to whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstable transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the MCO. The MCO may establish arrangements with hospitals whereby the MCO may send one of its own physicians with appropriate Emergency Room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient.

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

defined as one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

The MCO must pay all clean electronic and paper claims for covered services from both in-network and out-of-network providers within thirty (30) calendar days of receipt, except to the extent the provider has agreed to later payment in writing.

The MCO must agree to specify the date of receipt as the date the MCO receives the claim, as indicated by its date stamp (including electronic date stamp) on the claim, and date of payment as the date of the check release or other form of payment release to the provider.

The MCO must submit monthly a claims aging report that provides information on all overdue clean claims for both in-network and out-of-network providers as noted in Appendix D.

The MCO must pay both in-network and out-of-network providers interest at eighteen percent (18%) per annum, calculated daily for the full period in which the clean claim remains unpaid beyond the thirty (30) calendar day clean claims payment deadline. Interest owed to the provider must be paid on the same date as the claim. The interest paid to the providers will not be reported as a part of the MCO encounter data. This provision does not apply to payments made due to a rate change per Article III, Section 3.7.9.

As related to the sanction outlined in Appendix F, the MCO must meet a ninety percent (90%) threshold for timely claims payment (ninety percent [90%] of total clean claims within thirty [30] days), which aligns with 42 CFR §447.45(d)(2) for FFS Medicaid.

3.7.8 Payments for Provider-Preventable Conditions

Section 2702(a) of the Affordable Care Act (ACA) prohibits federal financial participation (FFP) payments to States for any amounts expended for providing medical assistance for PPCs, including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). PPCs are hospital-acquired conditions not present on hospital admission, the wrong procedure performed on a patient, and procedures performed on a wrong patient or body part.

The MCO may not make payments for PPCs as defined by the federal regulations and the Department policy in accordance with 42 CFR §438.6 and 42 CFR §447.26. The MCO will track PPC data and make it available to the Department upon request.

Under 42 CFR §447.26(b), *other provider-preventable condition* means a condition occurring in any health care setting that meets the following criteria:

1. Is identified in the State plan;
2. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
3. Has a negative consequence for the beneficiary;
4. Is auditable; and

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 measurable 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:

1. A thorough description of the MCO's APM initiatives;
2. Goals and outcome measures for the Contract year;
3. Description of monitoring activities to occur throughout the year;
4. Evaluation of the effectiveness of the previous year's initiatives;
5. Summary of lessons learned and any implemented changes;
6. Description of the most significant barriers; and
7. Plans for next Contract year.

3.7.11 Requirements for Provider-Administered Drug Reimbursement

All outpatient medical claims for provider-administered drugs must contain a Healthcare Common Procedure Coding System (HCPCS) code, a National Drug Codes (NDC) number, the NDC unit of measure, and the NDC quantity. The MCO must edit claims using the West Virginia's NDC to HCPCS Crosswalk file provided to the MCO monthly. The MCO must deny the entire claim or claim line item, if such a claim is missing the NDC information, or the NDC is not valid for the corresponding HCPCS code, as the drug is not considered a covered Medicaid benefit. This requirement applies to Medicare cross-over claims in addition to the other claims where a third party paid a portion of the claim.

3.8 Prohibitions on Inappropriate Provider Incentives

The MCO must comply with regulatory requirements regarding provider incentives as specified in 42 CFR §417.479, 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210. The MCO may not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary covered services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

As specified in 42 CFR §417.479, MCOs that operate physician incentive plans that place physicians or physician groups at substantial financial risk must conduct enrollee surveys. These surveys must include either all current Medicaid enrollees or their representatives in the MCO and those who have disenrolled (other than because of loss of eligibility) in the past twelve (12) months, or a statistically valid sample of these same enrollees and disenrollees. The surveys must address enrollee/disenrollee satisfaction with the quality of services provided and the accessibility of the services and must be conducted on an annual basis.

The MCO must collect the following information annually and make it available to the Department and CMS upon request, within ten (10) business days.

- Whether services not furnished by the physician or physician group are covered by the incentive plan.
- The type or types of incentive arrangements, such as bonus, capitation.
- The percent of any bonus the plan uses.
- Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.
- The patient panel size and, if the plan uses pooling, the pooling method.

- 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(6^{th}) 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.

enrollees. Such written assurance must be provided annually with the MCO's marketing plan and with each submission of new or revised marketing materials.

Statements that will be considered inaccurate, false, misleading include, but are not limited to, any assertion or statement (whether written or oral) that:

- The potential enrollee must enroll in the MCO in order to obtain benefits or to not lose benefits; or
- The MCO is endorsed by CMS, ACF, the federal or state government, or similar entity.

The MCO must request BMS review and receive approval for marketing materials prior to their distribution. Any changes to marketing materials must be submitted to BMS for approval. Any marketing materials submitted for BMS approval will be reviewed within forty-five (45) calendar days of submission. As soon as possible after submission, BMS will issue a written review decision to the MCO.

4.2 Enrollment

4.2.1 Process

The MCO will conduct continuous open enrollment during which the MCO must accept enrollees eligible for coverage under this Contract in the order in which they are enrolled without regard to health status of the enrollee or any other factors. The MCO will accept individuals who are eligible in the order in which they apply, without restriction unless authorized by CMS (42 CFR §438.3(d)) and up to its enrollment limits as discussed below. The MCO must accept enrollees in the order in which they apply (i.e., the order in which their enrollment information is transferred by the Department) up to the limits set by the Department. The MCO may not attempt to discourage or delay enrollment of eligible Medicaid enrollees.

4.2.1.1 Pre-existing Conditions

The MCO must assume responsibility for all covered medical conditions of each enrollee inclusive of pre-existing conditions as of the effective date of enrollment in the plan. The MCO must have a process for determining which enrollees may have pre-existing, chronic, or catastrophic illnesses, conducting outreach, and developing appropriate treatment plans for these enrollees as described in Article III, Section 6.3.

4.2.1.2 Confinement to an Inpatient Care Facility at Time of Enrollment or Disenrollment

Notwithstanding Article III, Section 8.4.1, Responsibility for Inpatient Care, if an enrollee is confined to an inpatient care facility on the effective date for initial enrollment with the MCO, coverage of inpatient facility charges (including charges at a transfer facility, if the enrollee is transferred during the stay, or within the facility) will be the responsibility of the Department until the enrollee is discharged. The MCO is responsible for all other covered services provided on or after the effective date of MCO enrollment, including but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care. Long-term acute care facilities compensated on a per diem basis are excluded from these provisions.

The MCO is responsible for all charges during the inpatient newborn stay if such newborn is born to a mother who is a current MCO enrollee until the newborn's discharge. For instances that

the MCO does not receive permanent identification for the newborn after ninety (90) calendar days, the MCO may reverse the claims.

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 both the Department and the DoHS Customer Service Center.
- Processing completion within thirty (30) calendar days of the date of birth.
- Submission of the newborn reporting form to the Department and the DoHS Customer Service Center 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 report 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 gain the Department's approval. The MCO must notify the Department forty-five (45) calendar days prior to the desired effective date of the change. The Department will issue its approval or disapproval in thirty (30) calendar days, subject to the Department's timely receipt of all necessary information from the MCO to make the determination. If the change is an increase, the MCO must demonstrate its capability to serve additional enrollees. An increase will be effective the first (1st) of the month after the Department confirms additional capacity exists.

4.2.4 Disenrollments

The term "disenrollment" will be used to refer to the process of enrollees leaving the MCO. Disenrollment for children in foster care may be initiated by the Department or by the child's caregiver. Disenrollment for children and youth eligible and enrolled in the MCO through the CSED waiver may be initiated by the Department or the child's parents or guardians and will result in loss of CSED waiver services and the child's MCO enrollment slot.

The MCO must have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when an enrollee is disenrolled from the MCO and enrolled in an MHT/WVHB MCO, a commercial health plan, or Medicaid FFS.

4.2.4.1 MCO-Initiated Disenrollment

Involuntary beneficiary disenrollment from the MCO may occur for the following reasons:

1. Continuous placement in a nursing facility, State institution or intermediate care facility for intellectual/developmental disabilities for more than thirty (30) calendar days;
2. Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment in an MCO, if the beneficiary does not meet the eligibility requirements for eligibility groups permitted to enroll in an MCO, or after a request for exemption is approved if the beneficiary was enrolled while their exemption request was being considered; or
3. Beneficiary death.

The MCO may not initiate disenrollment for any enrollee except as specified above. The MCO may not terminate enrollment because of an adverse change in the enrollee's health status; the enrollee's utilization of medical services; diminished mental capacity; or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this or other enrollees). The MCO may not request disenrollment because of an enrollee's attempt to exercise his or her rights under the grievance system. The MCO must assure the Department that terminations are consistent with the reasons permitted under the contract. The Department has responsibility for promptly arranging for services for any enrollee whose enrollment is terminated for reasons other than loss of Medicaid eligibility.

When the MCO determines an enrollee has moved out of state, the MCO should notify the Department to research the case to determine if the enrollee is no longer eligible.

In the case of continuous placement in a nursing facility, State institution, or intermediate care facility for the mentally retarded for more than thirty (30) calendar days, the MCO must notify the Department within five (5) business days following the thirtieth (30th) day of admission. The effective date of the disenrollment will be no later than the first (1st) day of the second (2nd) 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 meet requirements in CFR 42 §438.10(d)(2) and §438.71(a) and 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).

4.4 Materials

4.4.1 Enrollee Information Requirements

Enrollee paper and electronic informational materials relating to the Medicaid and WVCHIP program must be consistent with the requirements of 42 CFR §438.10 and this contract. The enrollee must be informed that the information is available in paper form without charge upon request and must be provided with the information within five (5) business days.

Electronic information must be placed on a website that is prominent and readily accessible. It must be provided in an electronic form which can be electronically retained and printed.

The MCO must inform the enrollee of the information that is available through application programming interfaces (APIs) and how to access such information. The information available through APIs shall include, but shall not be limited to, the information required by 42 CFR § 431.60, §438.3(e)(2), and §438.10(g)(2)(ix).

Enrollee information provided by the MCO must be in a conspicuous font size (no smaller than twelve (12) point), easily understood and readable at the sixth (6^{th}) grade level (Grade 6.9 or below), and available in the language(s) of the major population groups served and, as needed, in alternative formats (i.e., Braille) for those who are unable to see or read written materials. The MCO must make auxiliary aids and services, as well as oral interpretation services available in all non-English languages to all enrollees and potential enrollees free of charge. The MCO must notify enrollees that oral interpretation services are available for any language, that written information is available in prevalent languages, and how to access those services. Written materials must include taglines whenever taglines are necessary to ensure meaningful access by limited English proficiency (LEP) individuals to a covered program or activity and be in the prevalent non-English languages and large print (in a font size no smaller than eighteen (18) point) explaining the availability of written translation or oral interpretation and the toll-free and teletypewriter (TTY)/telecommunication device for the deaf (TDD) telephone number of the MCO. The MCO must make its written material available in the prevalent non-English languages, as identified by the Department in accordance with Article III, Section 4.7.

4.4.2 Member ID Cards

The MCO must establish a process by which member ID cards can be obtained via an electronic portal and available by mail upon request. The card must not be overtly different in design from the card issued to the MCO's commercially enrolled enrollees. The MCO must issue all enrollees a permanent identification card within five (5) business days of enrollment through its electronic portal. The MCO may issue one (1) identification card for all covered benefits except for a dental benefit card, which may be issued separately. PCP information must be updated as soon as it becomes available. The MCO must issue a replacement card within five (5) business days of an enrollee's request. The MCO is not required to issue a new card if the enrollee has been previously enrolled with the MCO and received a card within the past twelve (12) months unless a new card is requested.

The card must include at least the following information:

1. Beneficiary name;
2. State-assigned beneficiary Medicaid identification number;
3. MCO name;
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;
2. The phone number which can be used for assistance in obtaining emergency care;
3. 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;
4. A description of all available Contract services, including amount, duration, scope, and how to access those services (e.g., whether the enrollee can self-refer to the service or if a referral or prior authorization is needed); and an explanation of any service limitations or exclusions from coverage;
5. A description of any restrictions on the enrollee's freedom of choice among network providers;
6. The toll-free phone number for the enrollee services department, medical management, and any other unit providing services directly to enrollees, along with their hours of operation, and a description of its function;
7. Complaints, grievance, appeal, and state fair hearing definitions and procedures, including:
    a. The right to file grievances and appeals;
    b. Filing procedures, requirements, and timeframes for complaints, grievances and appeals, and state fair hearing;
    c. The method of obtaining a hearing and the rules governing representation at a hearing;
    d. The right to request a State fair hearing after a determination has been made on an enrollee's appeal, which is adverse to the enrollee;
    e. The availability of assistance if filing grievances and appeals, the toll-free numbers available for filing a grievance or appeal by phone;
    f. The opportunity to have benefits continue if the enrollee files an appeal or request for a state fair hearing within the Department specified timeframes upon request; and
    g. The requirement that enrollees may have to pay the cost of services received while the appeal is pending, if the final decision is adverse to the enrollee;
8. How to report suspected fraud, wasted, or abuse;
9. Disenrollment policies;
10. How to obtain EPSDT services;
11. How to obtain SNS;

12. Information on family planning services, including a discussion of enrollees' right to self-refer to in-network and out-of-network, Medicaid-participating family planning providers;
13. Information on the process of selecting and changing the enrollee's PCP;
14. Information concerning policies on advance directives;
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;
37. Information on an enrollee's right to access provider directory information through a publicly accessible API, including the types of information available through the API and how to access it;
38. Any significant changes, as defined by the Department, to the information above, at least thirty (30) calendar days before the effective date of the change and no later than the actual effective date;
39. The MCO's policies regarding the appropriate treatment of minors;
40. The MCO must advise enrollees at least annually of their right to request and obtain the above information;
41. Cost-sharing policies, including but not limited to exemptions for certain categories of enrollees and services;
42. Policies regarding the use of oral interpreters for minors and in case of emergency;
43. A list of counseling or referral services that the MCO does not cover because of moral or religious objection, including instructions for how the enrollee can obtain information from BMS about how to access those services; and
44. Information deemed mandatory by BMS.

The MCO must make modifications in the enrollee handbook language, if directed to do so, to comply with the requirements as described above.

4.4.3.2 Availability of Enrollee Handbook

In addition, the MCO must make the following information available to enrollees on request:

1. Information on the structure and operation of the MCO;
2. The procedures the MCO uses to control utilization of services and expenditures;
3. The number of grievances and appeals and their disposition in the aggregate, in a manner and form specified by the Department and/or Department of Insurance; and
4. A summary description of the method of compensation for physicians.

Some of the above information may be included as inserts or attachments to the handbook.

4.4.4 Provider Directory

The MCO must notify enrollees annually of their right to request and obtain a provider directory, and must provide a copy of the most current paper-based provider directory within five (5) business days of an enrollee request. Additionally, the MCO must publish and keep current its provider directory on the MCO website, along with information on how to access the MCO's provider directory information through use of an API as specified in Article III, Section43.4.5 on this contract.

In accordance with 42 CFR §438.10(h), the provider directory must include:

- The provider's name and any group affiliation,
- Specialty, as appropriate,
- Locations with street addresses,
- 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.
- Whether the provider offers covered services via telehealth.

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.
- CMS-designated Birthing-Friendly Hospitals and Health Systems in the State. Effective January 1, 2026, the MCO must indicate Birthing-Friendly Hospitals and Health Systems by name, address, city, state and zip code.

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.

The MCO's electronic provider directory must be maintained on the MCO's public website in a form that can be electronically retained and printed. The electronic directory must be updated no later than thirty (30) calendar days after the MCO receives updated provider information.

In addition to its paper and electronic directories, the MCO must implement and maintain a publicly accessible standards-based API as described at 42 CFR § 431.70, which must include all information specified by 42 CFR § 438.10(h)(1) and (2). This publicly accessible, provider directory API must be kept current on the MCO website and updated no later than thirty (30) calendar days after the MCO receives updated provider information.

Additionally, the MCO must deliver an updated provider directory to the enrollment broker monthly via an SFTP process, or when necessary, via any alternative data transmittal process directed by the Department. The MCO shall also submit the provider directory annually to BMS for review and approval by October 31st.

4.4.5 MCO Internet Website

The MCO must develop and maintain a public website to provide general information about West Virginia Mountain Health Promise, the provider network, customer services, and the complaints and appeals process for enrollees, foster families, adoptive families, parents or guardians of children enrolled with an SED, CPS workers, and providers. The MCO must ensure through its website that enrollees, their families, and CPS workers have access to the most current and accurate information concerning the MCO's network provider participation, including how to access such information through the use of APIs. MCO-developed enrollee and provider materials published to the MCO website including, but not limited to, the enrollee handbook, provider directory and provider manual must be searchable and include the most recent revision date. The MCO must provide information on its website, including but not limited to, materials as specified in this contract and the following:

1. An overview of services provided and how to access services, including telehealth and medication-assisted treatment, as applicable.
2. Toll-free enrollee services and transportation scheduling numbers;
3. 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.

4. Community resource library including but not limited to newsletters, links to community-based SDoH resources (e.g., for transportation, housing, and food), and directed educational materials that best meet the needs of the populations being served in accordance with federal and state marketing regulations; and
5. Information on patient wellness programs, healthy habits, community group meetings, and the Family Resource Network (FRN).

The MCO must have a secure portal with user specific log-in credentials that allow role-based appropriate access to confidential, child-specific information. The secure portal must include, but is not limited to:

- Enrollee-specific information;
- Service authorization statuses including SNS services;
- 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 protective devices such as seatbelts, safety helmets, and safety glasses. These programs must be conducted by qualified personnel. The MCO must also offer periodic screening programs that in the opinion of the medical staff would effectively identify conditions indicative of a health problem.

The MCO must periodically remind and encourage their Medicaid enrollees of the following:

- To use benefits including physical examinations that are available and designed to prevent illness.
- Of the importance of keeping appointments, which include, but are not limited to, medical and/or dental appointments, and preventive care screenings. The MCO must consider approaches to removing potential barriers to care, monitoring utilization, and any interventions provided if an enrollee has not had a screening as recommended by the Centers for Disease Control and Prevention.

The MCO must keep a record of all activities it has conducted to satisfy this requirement.

4.5.3 Health Screenings

The MCO may offer health screenings at community events, health awareness events, and in wellness vans to its enrollees and other members of the community. In such cases, the MCO must transmit a summary of the health screening to the enrollee's assigned PCP if the enrollee is enrolled with the MCO.

The MCO must instruct each enrollee that receives a screen to contact his or her PCP if medical follow-up is necessary and must ensure that each enrollee receives a printed summary of the assessment information to take to his or her PCP. The MCO is encouraged to transmit a summary of the assessment information directly to each enrollee's PCP.

4.5.4 Advance Directives

The MCO must comply with 42 CFR §422.128, and applicable West Virginia state law including WV §16-30-8, relating to written policies and procedures respecting advance directives, including the following:

1. Providing written information to enrollees concerning their rights under State law to make decisions about their medical care, including accepting or refusing medical or surgical treatment, and to formulate advance directives and concerning the MCO's policies with respect to the implementation of such rights; this information must be included in the enrollee handbook;
2. Ensuring that written information reflects changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;
3. Documenting in the enrollee's medical record whether or not the enrollee has executed an advance directive;
4. Not conditioning the provision of care or otherwise discriminating against an enrollee based on whether the enrollee has executed an advance directive;
5. Ensuring compliance with requirements of state law respecting advance directives;
6. Providing education for staff and the community on issues concerning advance directives; 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;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion; and
- To be furnished health care services as set forth in this contract.

4.6.2.1 MCO's Policies and Procedures to Protect Enrollee Rights

The MCO must have policies and procedures to protect and promote these rights, as follows:

1. **Enrollee privacy**
   The MCO must implement procedures to ensure the confidentiality of medical records and any other health and enrollment information that identifies a particular enrollee in accordance with Article II, Section 6.8.
2. **Accessible 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 must also ensure that enrollees have the right to access emergency health care services, consistent with the enrollee's determination of the need for such services as a prudent layperson, and post-stabilization services.
3. **Provider choice**
   The MCO must allow each enrollee to select his or her PCP from among those accepting new Medicaid enrollees in accordance with Article III, Section 4.2.

   Each enrollee referred to a specific provider for any service other than primary care must have an opportunity to refuse care from the designated provider and to select a different affiliated provider.
4. **Provider-enrollee communications**
   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 following:

i. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii. Any information the enrollee needs for deciding among all relevant treatment options; or

iii. The risks, benefits and consequences of treatment or nontreatment.

5. Participation in decision-making

The MCO must permit the enrollee's authorized parent or authorized representative to facilitate care or treatment decisions when the enrollee is unable to do so. The MCO must provide for enrollee or authorized representative involvement in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment, and comply with requirements of Federal and State law with respect to advance directives. This includes:

i. Providing written information to clients concerning their rights under State law to accept or refuse medical or surgical treatment and to formulate advance directives and concerning the MCO's policies with respect to the implementation of such rights (this information must be included in the enrollee handbook);

ii. Documenting in the enrollee's medical record whether or not the enrollee has executed an advanced directive;

iii. Not conditioning the provision of care or otherwise discriminating against an enrollee based on whether the enrollee has executed an advance directive;

iv. Ensuring compliance with requirements of state law respecting advance directives; and

v. 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 handbooks, in alternative formats (i.e., large print, Braille, cassette and diskette for participants with sensory impairments).

4.7.3 Cultural Competency

The MCO must encourage and foster cultural competency among its providers. Culturally appropriate care is care given by a provider who can relate to the enrollee and provide care with sensitivity, understanding, and respect for enrollee's culture and background.

4.7.4 Disabled Access

The MCO must comply with the ADA; the ADA's requirements apply to both the MCO and its providers.

All facilities are readily accessible to, and usable by, individuals with disabilities, and auxiliary aids and services are provided to ensure effective communication, in compliance with Title III of the ADA.

4.8 Grievances and Appeals

The Contractor must establish and maintain an organized grievance system for enrollees that includes grievance and appeal procedures, one (1) level of appeal, and access for enrollees to a state fair hearing in compliance with federal requirements including 42 CFR Part 431 subpart E and West Virginia Statutes 33-25A-12. The Department must approve in writing the MCO's grievance system and related notices to enrollees.

4.8.1 MCO Enrollee Grievance and Appeal Procedures

Enrollees or their authorized representative may file a grievance as defined in this Contract and federal regulations and regarding any aspect of service delivery provided or paid for by the MCO. Grievances may address any provision of the MCO's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, reductions, cancellations or non-renewals of enrollee coverage; failure to provide services in a timely manner, observance of an enrollee's rights as a patient; and the quality of the health care services rendered.

The enrollee may file an appeal to seek a review of an adverse benefit determination taken by the MCO as defined in 42 CFR §438.400(b).

4.8.1.1 Grievance and Appeal Procedures: General Requirements

The MCO must establish and maintain internal grievance and appeal procedures to permit eligible enrollees to challenge the denials of coverage of medical assistance or denials of payment for medical assistance. The procedures must be consistent with 42 CFR 438 Subpart F, provide adequate and reasonable procedures for the expeditious resolution of grievances initiated by enrollees, and be administered at no cost to the enrollee. The MCO must receive Department approval for its procedures.

The MCO's grievance and appeals procedures must include, but not be limited to, the following:

1. Make available steps to resolve the grievance, including providing a detailed description of the MCO's grievance and appeal procedures in the enrollee handbook. The MCO must also provide all providers and Subcontractors upon entering into a contract with the Plan, 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, or legal representative of a deceased enrollee's estate, and the MCO must inform the enrollee of the limited time available sufficiently in advance of the resolution timeframe for appeals.

The MCO must maintain an accurate record of each grievance and appeal, containing the name of the covered person for whom the appeal or grievance was filed, a general description of the reason for the grievance or appeal; the date received; the date of each review or review meeting; the resolution at each level of the grievance or appeal, if applicable; the date of resolution at each level, if applicable. The MCO must maintain records in a manner accessible to the State and available to CMS or ACF upon request for no less than ten (10) years. Copies of the grievances and the responses thereto must be available to the public for inspection for five (5) years.

4.8.1.2 Grievance and Appeal Procedures: Grievance Timeframes

The MCO must address timeframes specific to enrollee grievances in the grievance and appeal procedures including, but not limited to, the following:

1. Process and provide notice to affected parties regarding the enrollee grievance in a reasonable length of time not to exceed ninety (90) calendar days from the day the MCO receives the grievance, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee;
2. Ensure that standard resolution and notice for a grievance occurs with the timeframes established by the Department and that such timeframes may be extended up to fourteen (14) calendar days upon the request of the enrollee or if the MCO shows that additional information is necessary and that the delay is in the interest of the enrollee; and
3. Ensure that if the timeframe for resolving a grievance is extended for any reason other than an enrollee request, the MCO must give the enrollee written notice, within two (2) calendar days, of the reason for the delay and inform the enrollee of the right to file a grievance if he or she disagrees with the decision.

4.8.1.3 Grievance and Appeal Procedures: Appeal Timeframes

The MCO must address timeframes specific to enrollee appeals in the grievance and appeal procedures including, but not limited to, the following:

1. The time limit for the enrollee or his representative to file an appeal is sixty (60) calendar days from the date on the notice of adverse benefit determination;
2. The MCO must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date);
3. The MCO must process and provide notice to affected parties regarding the appeal in a reasonable length of time not to exceed thirty (30) calendar days from the day the MCO receives the appeal, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee;
4. Standard resolution and notice of appeals must occur with the timeframes established by the Department and may be extended up to fourteen (14) calendar days upon the request of the enrollee or if the MCO shows that additional information is necessary and that the delay is in the interest of the enrollee; and
5. 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.

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.

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 expeditiously as the enrollee's health condition requires and no later than the date the extension expires;
2. Resolution and notice for an expedited appeal must occur within the shorter of the following two timeframes: 1) seventy-two (72) hours after the MCO receives the appeal or 2) the timeframe specified in the West Virginia Statute 33-25A. The seventy-two (72) hour timeframe may be extended by up to fourteen (14) calendar days upon the request of the enrollee, his or her authorized representative, or provider, or if the MCO shows that additional information is required and that the delay is in the interest of the enrollee;
3. The MCO must make reasonable effort to provide oral notice of disposition of an expedited appeal; and
4. If the timeframe for resolving an expedited appeal is extended for any reason other than the request of an enrollee, his or her authorized representative, or provider, the MCO must give the enrollee, his or her authorized representative, or provider 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.

4.8.3 Notice of Adverse Benefit Determination

The notice of adverse benefit determination must be in writing and must meet the readability requirements of Article III, Section 4.4 of this contract. The Department will provide a model enrollee notice that the MCO is required to use.

1. The notice must include the following information:
    a. The adverse benefit determination taken or intended to be taken by the MCO;
    b. The reasons for the action, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. This information includes medically necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

c. The right of the enrollee, his representative, or his provider to appeal the adverse benefit determination to the MCO;

d. The enrollee's right to request a state fair hearing, including information on exhausting the MCO's one (1) level of appeal;

e. The procedures for filing an appeal and state fair hearing;

f. Circumstances and procedures for requesting an expedited resolution; and

g. The enrollee's right to and policies and procedures regarding the continuation of benefits while the resolution of the enrollee's appeal is pending.

2. The notice of adverse benefit determination must be mailed:

a. For termination, suspension or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the date of the adverse benefit determination;

b. No later than the date of adverse benefit determination if:

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.

4.8.5 State Fair Hearing

The state fair hearing process will be the responsibility of the Department as delegated to the West Virginia Board of Review.[13] The MCO is responsible for cooperating with the State in the fair hearings process and is considered a party to state fair hearings. Other parties to the State fair hearing include the Department, the enrollee and his or her representative or the representative of a deceased enrollee's estate. The MCO's responsibilities include, but are not limited to the following requirements: ensuring and documenting that the enrollee's appeal is regarding MHP covered benefits or services, including EPSDT, in accordance with 42 CFR 431.220, providing any required documentation, participating in required meetings, and abiding by the Department's final decisions, including decision to settle a case with the enrollee. The MCO must also provide enrollees with information about the right to request a state fair hearing as set forth in this contract. Pursuant to the West Virginia Common Chapter §710.24, the State shall make a final decision within ninety (90) calendar days of the request for a hearing.

4.8.6 Continuation of Benefits

The MCO must continue the enrollee's benefits while an appeal or state fair hearing are pending when:

1. The enrollee or the provider files the appeal timely (timely filing means on or before the later of within ten (10) calendar days of the MCO mailing of the notice of adverse benefit determination or the intended effective date of the MCO's proposed adverse benefit determination);

---

[13] State fair hearing process is conducted by the West Virginia Department of Health Board of Review in accordance with the WV Common Chapter §710, Subpart A, Hearings for Applicants and Recipients of Public Assistance

2. The enrollee or provider is appealing a decision to terminate, suspend, or reduce a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The original period covered by the original authorization has not expired; and
5. The enrollee requests extension of benefits.

Benefits must be continued or reinstated until:

1. The enrollee withdraws the appeal or request for a state fair hearing;
2. The enrollee fails to request a fair hearing and continuation of benefits within ten(10) calendar days after the MCO mails the notice of resolution of the appeal of an adverse benefit determination against the enrollee;
3. The time period or service limits of a previously authorized service have been met; or
4. A state fair hearing office issues a hearing decision adverse to the enrollee.

If the resolution of the appeal or state fair hearing reverses the decision of the MCO to deny, limit, or delay services that were not furnished, the MCO must authorize or provide the disputed services promptly or as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination. If the resolution of the appeal or state fair hearing reverses the decision of the MCO to deny 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.

4.9.2 Services and Enrollees Subject to Cost-Sharing Obligations

The MCO and the MCO's providers must charge copays for the following MCO services or enrollees:

1. Inpatient and outpatient services;
2. Physician office visits, including but not limited to, office visits to an NP;
3. Non-emergency use of an emergency department; and
4. Any other enrollees identified by the MCO who are not specifically exempt.

All enrollees eligible for services under Phase One are exempt from cost-sharing requirements.

4.9.3 Cost-Sharing Obligations When Medicaid is Secondary Payer

Enrollees who have primary insurance other than Medicaid are exempt from Medicaid cost sharing obligations. When a third party has made a payment for a covered service and the MCO is the secondary payer, the Medicaid allowed amount must be calculated as the difference between the paid amount and the Medicaid-allowed amount compared to the sum of the co-insurance, copayment, and deductible amounts. The MCO is responsible for paying the lesser of either the difference amount or the summed amount.

4.10 Value-Added Services

Consistent with 42 CFR 438.3(e), the MCO may propose to offer Value-Added Services. If offered, the MCO will not receive additional compensation for the Value-Added Services from the Department. The MCO may report the costs of Value-Added Services as allowable medical

or administrative costs for the purposes of MLR calculation. The cost of Value-Added Services is not included in the MCO capitation rates. The Value-Added Services are not included in the Medicaid benefit package.

The MCO may not offer or advertise a Value-Added Service without the Department's approval. Value-Added Services must be submitted and approved by the Department as part of the MCO's initial readiness review during implementation and bi-annually. The MCO will submit the proposed Value-Added Services to the Department on the following schedule:

1. By October 1st of each calendar year for the January 1st publishing date; and
2. By April 1st of each calendar year for the July 1st publishing date.

For each Value-Added Service proposed, the MCO must:

1. Define and describe the Value-Added Service, including:
    a. Rationale for offering the Value-Added Service, including how it aligns with the MCO's enrollee needs;
    b. Detailed information about the process or actions the enrollee will be required to follow to obtain or access the Value-Added Services; and
    c. Description of if and how the MCO will identify enrollees who have met requirements, if any, to receive the Value-Added Service (e.g., completed smoking cessation activities).
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).

The MCO shall have an established population health approach, which includes, but is not limited to, (1) engaging enrollees across the entire care continuum, (2) promoting and incentivizing healthy behaviors and disease management, and (3) evaluating the enrollee population and coordinating prevention and wellness programs, as well as advancing evidence-based practices available to all enrollees.

The MCO shall collect and meaningfully use member-identified race, ethnicity, language, and SDoH data to identify and reduce disparities in health care access, services, and outcomes. The MCO shall consider information about SDoH, as identified by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC) for its care coordination services.

The MCO should establish a Social Determinants of Health Committee to monitor and improve population health outcomes, including addressing SDoH to assess overall health plan performance. This committee should be chaired by the MCO's Social Determinants of Health Director and involve enrollees, network providers, and stakeholders, as appropriate. Functions should include, but are not limited to:

- Establishing initiatives to further equitable healthcare among membership;
- Developing strategies to address the SDoH impacting enrollees; and
- Collecting and meaningfully using member-identified race, ethnicity, language, and SDoH data to identify and reduce disparities in healthcare access, services, and outcomes.

BMS reserves the right to request committee reports.

---

[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.

4.11.1 Social Determinants of Health (SDoH)

The MCO shall endeavor to enhance integrated physical and behavioral health care, active local involvement, and focus on enrollees and family through proactive case management activities that support enrollees living in their homes and community, increase enrollees' self-sufficiency, and address SDoH needs. The MCO shall develop strategies to address the SDoH impacting enrollees.

When implementing SDoH activities that meet the requirements in 45 CFR § 158.150(b) and are not excluded under 45 CFR § 158.150(c), the MCO may include the costs associated with these activities in the numerator of its MLR as activities that improve health care quality under 42 CFR § 438.8(e)(3).

4.11.1.1 SDoH Work Plan

The MCO shall develop an SDoH work plan as a component of QAPI program that is described in Article III, Section 6 and that aligns with the State's quality strategy. The MCO must submit the SDoH work plan to BMS as a sub-component of its QAPI plan. The MCO's initial SDoH work plan must include its own timelines, benchmarks, milestones and the following components:

1. Plan for increasing the systematic collection and documentation of enrollee-level SDoH data through screening;
2. Plan for promoting the use of International Classification of Disease (ICD)-10 Z codes for SDoH documentation;
3. Plan to increase provider understanding of SDoH;
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.

The MCO may include within the SDoH work plan initiatives to promote equitable healthcare, including but not limited to enhancing data capacity to inform equitable healthcare efforts and developing interventions to address structural systems and processes.

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;
- Annual training on customer service;
- Trauma-informed training that includes recognizing, understanding, and responding to the effects of all types of trauma, including guidelines to inform working with youth who may have been exposed to adverse childhood experiences (ACEs);
- Additional training relative to SDoH case management that the MCO deems necessary;
- Additional training for Enrollee Services representatives who perform outreach to enrollees with special healthcare needs upon enrollment. Topics should include, but are not limited to:
  - The culture of disabilities and chronic conditions;
  - Mental/behavioral challenges of the population;
  - Adverse childhood experiences (ACEs); and
  - Resources available to enrollees;
- For enrollee service representatives, training on the out-of-network referral process and carved-out services such as NEMT and pharmacy;

- Training on wraparound and CMCR for care coordination staff who will be reviewing for medical need and supporting coordination of care and wraparound child and family teams; and
- Other topics including serving enrollees with disabilities and chronic conditions, the culture of disability, the foster care system, mental and behavioral health challenges of the populations, ACEs, and resources available to enrollees.

The trainings listed above do not replace or subvert training requirements to educate MCO staff on how to recognize and screen for an enrollee's SDoH needs, why addressing an enrollee's SDoH needs is important, how they impact an enrollee's care, and how to connect enrollees with available community resources and social services. The MCO shall maintain records of staff trainings at all times.

4.11.1.4 Partnering with Community Resources

The MCO must collaborate and build partnerships with community-based organizations (CBOs), public health departments or social service providers to implement person-centered SDOH interventions that integrate physical and behavioral services and supports access to care. In addition, the MCO shall maintain a list of community resources and social services including key contact information to assist staff and providers with enrollee referrals.

4.11.1.5 Addressing SDoH Through Technology, Data Collection and Analytics

The MCO must make SDoH data collected through assessments, care management touch points and claims data to BMS upon request. This includes, but is not limited to, encouraging contracted providers to use ICD-10 Z-codes on provider claims.

The MCO must perform data analytics to identify enrollees' disparities and implement and report on the effectiveness of evidence-based interventions that are designed to address enrollees SDoH. This includes, but is not limited to:

- Number of enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level
- 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.

4.12.1.6 Transforming Maternal Health Model

The TMaH Model aims to improve maternal and child health outcomes while reducing Medicaid and WVCHIP program expenditures for maternal care through reduced spending on high-cost procedures such as c-sections for low-risk enrollees. A key focus of the model will be to increase access to home monitoring for diabetes and hypertension. The MCO must collaborate with BMS,

other MCOs, community organizations, and other BMS vendors as necessary throughout the planning and implementation of the Model. MCOs must meet all reporting requirements as directed by the State.

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. 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;
8. Organize and provide training and educational materials for MCO staff and providers to enhance their understanding of the values and practices of all cultures with which the MCO interacts;
9. Provide input to MCO management on how provider changes will affect enrollee access and quality/continuity of care; develop/coordinate plans to minimize any potential problems;
10. Review all informing material to be distributed to enrollees; and

11. Assist enrollees and authorized representatives to obtain medical records.

6. HEALTH CARE MANAGEMENT

6.1 Second Opinions

In accordance with 42 CFR §438.206(b)(3), the MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain a second opinion outside the network, at no cost to the enrollee.

6.2 Out-of-Network Services

In accordance with 42 CFR §438.206(b)(4), the MCO must cover out-of-network services that are otherwise covered under the Contract for the enrollee if the MCO's network is unable to provide such services. In accordance with 42 CFR §438.206(b)(5), the MCO must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network. In accordance with 42 CFR § 438.910(d)(3), the MCO must provide access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, and other factors in determining access to out-of-network providers for medical/surgical benefits. Services must be covered as adequately and timely as if such services were provided within the network, and for as long as the MCO is unable to provide them through in-network providers. To the extent possible, the MCO must encourage out-of-network providers to coordinate with the MCO with respect to payment.

6.3 Continuity and Coordination of Care

In accordance with 42 CFR §438.208(b)(1), the MCO must ensure an integrated approach to the continuity and coordination of care through use of an individual or entity that is formally designated as having primary responsibility for administering all services for the enrollee under this contract; the MCO must provide the enrollee or his representative with information on how to contact the designated individual or entity. The MCO must coordinate care across child-serving systems, including, but not limited to, the educational system, community services, and after-school programs.

The MCO must submit its care coordination program description in writing for BMS review and approval annually on October 1. If the MCO makes significant changes to its care coordination program, it must submit any changes to BMS for approval prior to implementing the change.

The MCO's care coordination program must describe the following components:

1. MCO's care coordination staffing, including the number of staff by role, qualifications, and physical location;
2. Training topics and frequency of training provided to MCO care coordination 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.

Regardless of the mechanism adopted for coordination of services, the MCO must ensure that each enrollee has an ongoing source of primary care. The MCO must assign enrollees to an appropriate healthcare professional who is formally responsible for coordinating the enrollee's overall healthcare, including, but not limited to, behavioral health.

The MCO shall have a process in place to assist enrollees who have a change in health status resulting in the need of additional services, which include, but are not limited to, care coordination assistance and supporting enrollees in making appointments. The MCO must

educate enrollees and their caregivers on the availability of such services and the assistance the MCO can provide in removing any barriers to access to care.

The MCO must have programs for coordination of care that include coordination of services with community and other social services locally available through contracting or non-contracting with providers in the area served by the MCO. The MCO must also ensure that enrollees are informed of specific health care needs that require follow-up; receive, as appropriate, training in self-care and other measures they may take to promote their own health; and comply with prescribed treatments or regimens.

In the instance where an enrollee transfers enrollment to a MHT/WVHB MCO or FFS, the MCO is required to provide transition of care clinical information to the MHT/WVHB MCO or to the Department to promote continuity of care.

6.3.1 Initial Health Assessment

In accordance with 42 CFR. §438.208(b)(3), the MCO is required to make a best effort to conduct an initial screening of each enrollee's health care needs, within thirty (30) calendar days of the effective date of enrollment for all new enrollees. If the initial attempt to contact the enrollee is unsuccessful, the MCO must make subsequent attempts to complete the assessment. 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 may conduct the enrollee's initial screening during the enrollee "welcome call" as defined in Article III, Section 4.5.1.

In accordance with 42 CFR. §438.208(b)(4), the MCO shall share with BMS or other MCOs serving the enrollee the results of the initial health assessment to prevent duplication. The results shall be transmitted in the timeframe and format required by BMS. The MCO must ensure that it maintains and shares, as appropriate, an enrollee health record in accordance with professional standards. In accordance with 42 CFR §438.208(b)(6), the MCO must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with all applicable privacy laws, including but not limited to the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E to the extent they are applicable, and the requirements of 42 CFR §2.1 – 2.67.

6.3.2 Coordination of Care

The MCO must have systems in place to ensure well-managed patient care, including at a minimum:

1. Management and integration of health care through PCP, or other means;
2. Systems to assure referrals for Medically Necessary specialty, secondary and tertiary care;
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:

1. Risk Level 0: Wellness Program
2. Risk Level 1: Low Risk Maternity, Health Risk Management and Care Coordination programs
3. Risk Level 2: Chronic Care Management, High Risk Pregnancy and Complex Case Management programs

The MCO must assign an initial risk level within the first thirty (30) days of enrollment for enrollees newly enrolled with the MCO. The MCO must review and update the risk level following the completion of the enrollee's health risk assessment.

The MCO shall establish a process to identify enrollees who need care plans with input from committees comprising family members, the enrollees, providers, the care coordinator, and a Department lead. The MCO must develop a care plan for all youth aged eighteen (18) and under, and as needed for individuals ages nineteen (19) to (26), to monitor progress towards select person-centered goals based on the enrollee's level of acuity.

For enrollees with low acuity, the MCO shall, at a minimum, monitor whether all preventive care and associated services have been received based on the appropriate periodicity schedule, and work with the enrollee and the enrollee's guardian or authorized representative to develop person-centered goals and intervention strategies to improve access if not received. For enrollees with higher acuity, the MCO must work with the enrollee and enrollee's guardian or authorized representative (if applicable) to develop person-centered goals, identify barriers and establish interventions to assist in addressing the specific needs of the youth in meeting their needs.

At a minimum, the MCO must reassess enrollees identified as high acuity needs in Risk Level 2 at least every twelve (12) months, when the enrollee's circumstances or needs change significantly, or at the request of the enrollee, enrollee's guardian or the enrollee's PCP.

The MCO must establish a care management program for pregnant women, which includes, but is not limited to the following:

a. Approach to providing health education (e.g., lead poisoning prevention/testing) and encouraging breastfeeding, nutrition, and exercise;

b. Promotion of prenatal care throughout the pregnancy and planning for postpartum services;

c. Communication with the OBGYN and enrollee; and

d. A process for risk stratification of pregnant women and for identifying high-risk mothers and babies to facilitate connections to services, community programs, and supports.

The MCO should collaborate with the Department's pharmacy program to provide coordinated care for the enrollee, including, but not limited to, those enrollees accessing psychotropic medications, and ensuring that needed medications are available to the enrollee after leaving an inpatient facility or changing levels of care for applicable populations.

The MCO must establish a process by which it will identify appropriate levels of support and services, including, but not limited to, support, placement, and discharge planning services. The MCO shall support the Department caseworker in identifying the needs of the family and assist in developing case plans to meet those needs in the least restrictive manner. The MCO contribution should include identifying appropriate placements, coordinating with the 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;
4. Coordinate with non-PRTF providers to deliver MCO-covered services;
5. Submit demographic data on the enrollee, including ethnicity and LGBTQ status, if available, to help with monitoring disproportionate utilization of these services.

The MCO must provide coordination services to assist enrollees in arranging, coordinating and monitoring all medical, behavioral, socially necessary, and support services. Each PCP is to act as the coordinator of care for his/her patients' overall care, and this requirement needs to be included in provider contracts.

The MCO must coordinate with BMS and any entities determined by the Department in developing access, coordination, and training for Children's Mobile Crisis Response (CMCR) services.

The MCO must also designate an individual or entity to serve as a care manager for enrollees with ongoing medical conditions and special health needs. Responsibilities of the MCO's designee includes:

1. Assessing enrollees' risk of readmission or deterioration in order to determine the LOC needed;
2. Identifying medical procedures to address and/or monitor the conditions;
3. Developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring;
4. Tracking completion of treatment;
5. Identifying, tracking, and remediating gaps in care;
6. Identifying processes for episodic and/or catastrophic care management interventions.
7. Coordinating hospital admission/discharge planning and post-discharge care and continued services (e.g., rehabilitation);
8. Providing assistance to enrollees in obtaining behavioral health, SNS, and other community services; and
9. Providing assistance in the coordination of behavioral health, physical health, and all other services.

The MCO must assist any enrollee seeking information about workforce opportunities. The MCO must refer inquiries to a local workforce office for additional assistance in establishing employment. If the enrollee identifies a behavioral health or medical need that is preventing the individual from establishing employment, the MCO must make all reasonable effort (the MCO must make at least three (3) contact attempts at three different times of day) to enroll the enrollee in care management and work with the enrollee to establish a care plan to help address these barriers.

The MCO shall have a process in place to comprehensively manage discharge plans and transitions of care from inpatient settings to help prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes, which includes, but is not limited to:

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 delay or prevent access, such as prior authorizations or step-therapy failure requirements. Enrollees shall be able to access patient-centered education and counseling on all FDA-approved birth control methods.

6.3.3.2 Fee-For-Service Health Care

The MCO must follow established Medicaid procedures and provide referrals and assistance in scheduling appointments to enrollees in need of covered services outside of the scope of this Contract as defined in Contract Appendix A. The MCO must also comply with all policies developed by the Department for linking the services provided by the MCO to those non-covered

services. These services will be tracked and monitored by the plans and the Department through submission of encounter forms to the Department.

6.3.3.3 WIC Program

The MCO must work with the Department to provide for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants and Children (WIC) and must provide timely notice and referral to WIC in accordance with section 1902(a)(53) of the Social Security Act. The MCO must refer potentially eligible women (e.g., pregnant, breastfeeding, and less than six (6) months postpartum), infants, and children under the age of five (5) to WIC. If available, the MCO must include timely (not more than sixty (60) calendar days after referral) referral of medical information (length/height, weight, hemoglobin and medical condition which influences consumption, adsorption, or utilization of food nutrients) to WIC and comply with all State and Federal privacy laws in doing so.

6.3.3.4 School-Health Related Services

MCOs must work with the providers of school-health related services to coordinate care.

6.3.3.5 Community and Social Services

The MCO must have programs for coordination of care that include the integration of services with community and social services generally available through contracting or non-contracting providers in the local community served by the MCO. The MCO shall develop a process that promotes community integration of members who have select risk factors including, but not limited to homelessness; at risk of homelessness and substance abuse. The level of community coordination will vary in scope and frequency depending on the member's level of care/need.

6.3.4 Coordination of Care for Persons with Special Health Care Needs and SSI Eligibles

The MCO must have procedures for identifying individuals with complex or serious medical conditions. The MCO must complete identification and assessment of the individuals with complex or serious medical conditions within ninety (90) calendar days of the effective date of enrollment in the MCO. The MCO must use appropriate health care professionals in assessing those conditions, identifying medical procedures to address and/or monitor the conditions, and developing treatment plans appropriate for those enrollees determined to need a course of treatment or regular care monitoring. Treatment plans must specify an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan. The MCO must make all efforts to assure that a person-centered treatment plan is developed in collaboration with the enrollee's PCP, with participation from the enrollee and the enrollee's care manager (if a separate care manager has been designated in addition to the PCP), and in consultation with any 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 consistent with all State and Federal statutory and regulatory privacy requirements, including, but not limited to, 45 CFR parts §160 and §164 subparts A and E.

The MCO and OMCFH will collaborate as appropriate on quality improvement activities, education, and other initiatives targeted at improving the care and health outcomes for children with special health care needs.

For any child with special health care needs requiring medical foods, the MCO must accept the clinical evaluations conducted by the BPH's OMCFH. OMCFH will provide the enrollee's MCO

with the necessary information, including food type, amount, and duration, required to authorize medical foods. For MCO enrollees enrolled in the Title V Children with Special Health Care Needs program that do not require complete nutrition via tube, catheter, or stoma, the OFCMH will coordinate services with the nutritional foods' vendor and the State's fiscal agent. The MCO is responsible for providing medical food services for all other enrollees as otherwise consistent with the West Virginia Medicaid State Plan.

6.3.5 Care Coordination with Drug Free Moms and Babies (DFMB) Sites

The MCO must comply with the Drug Free Moms and Babies (DFMB) policy established by the State within the West Virginia Medicaid Provider Manual at Chapter 521, Appendix B. The MCO must contract with all DFMB sites.

Medicaid enrollees participating in the in the DFMB Program must work with DFMB Care Coordinators at designated DFMB sites for services as defined in Chapter 521, Appendix B. The MCO remains responsible for coordination of all other Medicaid covered services available to the enrollee and must provide care coordination as required by Article III, Section 5.3 of this Contract.

As part of care coordination services, DFMB Care Coordinators, DFMB Community Health Workers, and the MCO's care coordination staff shall work together to provide referral sources, to re-engage DFMB participants at risk for loss of engagement, and to collaborate in addressing the findings from health-related social needs screenings. Throughout the enrollee's participation in the DFMB Program, DFMB Care Coordinators and MCO care coordination staff shall meet, at the time and frequency defined in Chapter 521 Appendix B, to coordinate across all Medicaid covered services available to the Medicaid enrollee.

6.3.6 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. For additional information on the process, see Article II Section 4.4 Voluntary and Involuntary Disenrollment.

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 a period of ninety (90) calendar days, even if that provider is not in the MCO's network, while a transition of care plan is developed. As part of the transition of care planning, the enrollee will be referred to appropriate in-network providers for needed services. As part of the transition of care planning, the enrollee will be referred to appropriate in-network providers for needed services. The MCO should assist in transferring necessary clinical information to the foster care enrollee's new in-network physical health or behavioral health provider.

Enrollees with procedures that are scheduled to occur after their new MCO effective date, but that have been authorized by either BMS or the enrollee's original MCO prior to the new MCO effective date will be covered by the enrollee's new MCO until the end of the current authorization period as granted by either another MCO or FFS, or until the MCO has evaluated and assessed the enrollee and issued or denied a new service authorization as outlined in Article III, Section 6.4.1. In accordance with West Virginia Code § 33-25A-8s, a prior authorization approved by either another MCO or FFS will be covered by the MCO for three (3) months if the services are provided within the State.

Enrollees who are in ongoing outpatient treatment that has been covered by BMS or another MCO prior to their new MCO effective date will be covered by the new MCO until the end of the current authorization period as granted by either another MCO or FFS, or until the MCO has evaluated and assessed the enrollee and issued or denied a new service authorization as outlined in Article III, Section 6.4.1.

Consistent with federal and state laws, Medicaid FFS or the MCO that was previously serving the enrollee will fully and timely comply with requests for historical utilization data from the new MCO or with requests for copies of enrollee medical records from the enrollee's new provider(s), as appropriate.

In addition, the MCO is required to establish a transition plan for those members who are aging out of the child welfare system, and work to coordinate referrals to community resources the member could engage, as needed. Such services included, but are not limited to, health care, education, employment, housing and other social needs.

The MCO must conduct outreach and transition planning efforts directed to enrollees with special healthcare needs, including, but not limited to, transition into the MHP program, transitions in placement, and surrounding crisis events.

In accordance with 42 CFR §438.208(b)(4), the MCOs must have in place procedures to share, with the State or other MCOs serving the enrollee, the results of any identification and assessment of the enrollee's needs to prevent duplication of those activities.

6.3.7 Coordination of Services

The MCO must implement a systematic administrative process to coordinate access to services, including non-capitated services. The MCO must coordinate with BSS, child protective services, providers, and community organizations that may not be providing covered services but are otherwise important resources to help Members in maintaining health and well-being.

The MCO must cooperate and coordinate with BSS for the care of a child or young adult who is receiving services from or has been placed in state conservatorship.

6.3.8 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 § 9-5-32, 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.

Decisions to deny service authorization or to authorize a service in amount, duration or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease and who has knowledge of local patterns of care, as determined by the Department. As stated in Article II, Section 4.10 of this Contract, and in accordance with 42 CFR §438.210(a)(3)(ii), the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

Admission, continued stay, and discharge criteria used by the MCO must be communicated to all providers and enrollees when appropriate, and to individual enrollees when requested. In the case of any decision to deny, limit, or discontinue authorization of services, the MCO must notify the requesting provider and provide the enrollee written notice of such decision. The notice must meet the standards set forth in this contract.

In accordance with 42 CFR §438.210(c) and West Virginia Code § 9-5-32, the MCO must make authorization decisions and in the event of an authorization denial, provide written notice to the requesting provider and enrollee as expeditiously as required by the enrollee's health condition, and no later than five (5) business days of receiving the request for service for the purposes of standard authorization decisions, with the exception of the requirements in Article III Section 11.9 of this contract

In accordance with West Virginia Code § 9-5-32, if the information submitted is considered incomplete, the MCO must identify all deficiencies, and within two (2) business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the provider. The provider must provide the additional information requested within three (3) business days from the day the return request is received by the provider. The MCO must render a decision within two (2) business days after receipt of the additional information submitted by the provider. If the provider fails to submit additional information, the prior authorization is considered denied and a new request must be submitted.

In accordance with 42 CFR §438.210(d)(1), this five (5) business days period may be extended up to fourteen (14) additional calendar days upon request of the enrollee or provider, 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.

Failure to meet the required timeframes for at least ninety-five percent (95%) of authorization requests received will result in liquidated damages as outlined in Appendix F.

In accordance with 42 CFR §438.210(d)(2) and West Virginia Code § 9-5-32, the MCO must provide an expedited authorization for services in the following circumstances:

1. The provider indicates that the standard timeframe could seriously jeopardize the enrollee's life or health, or the safety of the enrollee or others due to the patient's psychological state;
2. The provider indicates that the standard timeframe could seriously jeopardize the enrollee's ability to attain, maintain, or regain maximum function; or
3. Where application of the timeframe for making routine or non-life-threatening care determinations in the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

In accordance with West Virginia Code § 9-5-32, if a health care practitioner requests and appeal by peer review for a rejected prior authorization request, the MCO must complete the peer-to-peer appeal process within five (5) business days from the date of the request 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.

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.

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. §9-5-32. In the event that there is a conflict between this contract and the standards in W. Va. §9-5-32, 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 initially and at any time material changes are made. 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 FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following: (1) until the end of the current authorization period as granted by either another MCO or FFS, or (2) until the MCO has evaluated and assessed the enrollee and issued or denied a new service authorization. In accordance with West Virginia Code § 33-25A-8s, a prior authorization approved by either another MCO or FFS will be covered by the MCO for three (3) months if the services are provided within the State.

5.4.1 Exemptions from Service Authorization Requirements

In accordance with West Virginia Code § 33-25A-8s, the MCO may not require a health care practitioner to submit a prior authorization for at least six (6) months, or longer as allowed by the MCO, if the health care practitioner meets the following: has performed an average of thirty (30) procedures per year and in a six (6) month time period during that year has received a ninety percent (90%) final prior approval rating.

At the end of the timeframe allowed by the MCO, the MCO must review the exemption prior to renewal. If approved, the MCO must grant the renewal for a time period equal to the previously granted time period, or longer as allowed by the MCO.

The MCO may conduct internal auditing of exemptions at any time and may be rescinded if the MCO determines the health care practitioner is not performing services or procedures in

conformity with the MCO's benefit plan, the MCO identifies substantial variances in historical utilization, or the MCO identifies other anomalies based on results of the internal audit. The MCO must provide a letter to the health care practitioner detailing the rationale for revocation of his or her exemption.

The MCO is not prohibited from requiring service authorization for the following: an experimental treatment, non-covered benefit, out-of-network services or procedures, or services or procedures where statute or BMS Medicaid policy requires benefit maximums or minimums.

The MCO must submit its process and policies for complying with these requirements to the Department for review and approval. On an ongoing basis, the MCO will submit any material changes to the process and policies to the Department for review and approval.

6.5 Rural Option

If the MCO is the single MCO contracted to provide services in a rural county as permitted in 42 CFR §438.52, the MCO will permit enrollees to choose from at least two (2) physicians, and to obtain services from an out-of-network provider under any of the following circumstances:

1. The necessary service or type of provider, in terms of training, experience, and specialization, is not available within the MCO network;
2. The enrollee's PCP or other provider determines that the enrollee needs related services that would subject the enrollee to unnecessary risk if such services were received separately and not all of the related services are available within the network; or
3. The Department determines that other circumstances warrant out-of-network treatment.

In addition, enrollees may access an out-of-network network provider that is the main source of a service to the enrollee for the first sixty (60) calendar days of enrollment.

A provider in the circumstances described above must be given the opportunity to join the MCO network under the same terms and conditions as other providers of that type. If the provider 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.

Medical records must also meet the standards specified in this contract. The MCO must implement appropriate policies and procedures to ensure that the MCO and its providers have the information required for effective and continuous patient care and for quality review, and must conduct an ongoing program to monitor compliance with those policies and procedures.

The MCO must ensure that each provider furnishing services to enrollees maintains an enrollee health record. PCPs must establish and maintain a confidential, centralized medical record for each enrollee that details care received. Each enrollees medical record must demonstrate coordination of patient care; for example, relevant medical information from referral sources must be reviewed and entered into enrollees' medical records. Medical records must be maintained in accordance with standards established by the MCO taking into account professional standards and best practices.

These standards and best practices must address health record content and organization, including specifications of basic information to be included in each health record that include at least the following:

1. Information needed to conduct utilization review as specified in 42 CFR §456.111 and 42 CFR §438.208(b)(5);
2. Patient identification information: patient's name or patient ID number on each page or electronic file;

3. Personal/biographical data: age, sex, address, employer, home and work telephone numbers, and marital status;
4. Entry date;
5. Provider identification;
6. Allergies: medication allergies and adverse reactions are prominently noted on the record, absence of allergies (no known allergies-NKA) is noted in an easily recognizable location;
7. Past medical history (for patients seen three (3) or more times): serious accidents, operations, illnesses, prenatal care, and birth (for pediatric patients);
8. Immunizations: for pediatric records (ages twelve (12) and under) there must be a completed immunization record or a notation that immunizations are up-to-date, and when subsequent immunizations, if any, are required;
9. Diagnostic information;
10. Medication information;
11. Identification of current problems: significant illness, medical conditions and health maintenance concerns are identified in the medical record;
12. Smoking/ethanol/substance use: notation concerning cigarette and alcohol use and substance abuse is present (for patients fourteen (14) years and over and seen three (3) or more times);
13. Consultations, referral, and specialist reports: notes from consultations, lab, and x-ray reports with the ordering physician's initials or other documentation signifying review, 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 Interoperability (USCDI) standard adopted at 45 CFR 170.213. Such information received by the MCO must be incorporated into the MCO's records about the current enrollee. With the approval and at the direction of a current or former enrollee or the enrollee's personal representative, the MCO must:
- Receive all such data for a current enrollee from any other payer that has provided coverage to the enrollee within the preceding five (5) years;
- Send all such data to any other payer that currently covers the enrollee or a payer the enrollee or the enrollee's personal representative specifically requests receive the data at any time the enrollee is currently enrolled in the MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) and up to five (5) years after disenrollment;
- Send data received from another payer under this paragraph in the electronic form and format it was received; and
- Comply with an enrollee's request to have their health data transferred from payer to payer.

The MCO must have policies and procedures in place to ensure that the identification and assessment of enrollee's needs are promptly shared with the State, other MCOs and private insurers and make all efforts to prevent duplication of these activities.

The MCO must comply with 45 CFR §170 and 45 CFR §171 electronic health record reporting program provision of the 21st Century Cures Act.

6.9 Confidentiality

The MCO must have written policies and procedures for safeguarding and maintaining the confidentiality of data, including medical records/enrollee information and adolescent/STD appointment records. The MCO's policies must be in accordance with the privacy requirements including, but not limited to 42 CFR §431.301-307, 42 CFR §431.60, 45 CFR parts 160, 162, 164, §170.215, and with the Federal Information Security Management Act (FISMA), upon their effective dates, to the extent the requirements are applicable. All enrollee information, medical records, data and data elements collected, maintained or used in the administration of this Contract must be protected by the MCO from unauthorized disclosure.

In seeking to protect such information from unauthorized disclosure, the MCO must conduct routine testing and monitoring of its API technologies, and update as appropriate, to ensure the APIs function properly, including assessments to verify that the APIs are fully and successfully implementing privacy and security features such as, but not limited to, those required to comply with HIPAA privacy and security requirements in 45 CFR parts 160, 162, 164, and 42 CFR parts 2 and 3, and other applicable law protecting the privacy and security of individually identifiable data.

The MCO must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with the administration of this contract. The MCO must prepare reports to meet the reporting requirements with respect to breaches of protected health information as defined in 45 CFR §164.400-414.

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.

6.10 Reporting Requirements

The MCO must demonstrate the MCO's ability to provide the services under this Contract efficiently, effectively, and economically. As part of the MCO's demonstration of its ability, the MCO must comply with all Department reporting requirements. Such requirements encompass the content of the reports, the format in which they must be transmitted, and the timeframes for submission. Appendix D summarizes reporting requirements and timeframes. All MCO reports submitted under this Contract must reflect program-related data only unless otherwise requested by the Department.

The MCO must certify submissions of all reports listed in Appendix D and data submitted to the Department and an authorized agent of the Department, if such data is the basis upon which the Department payments are made to the MCO. The data must be certified by the MCO's CEO or CFO, or an individual who has authority to sign for and who reports directly to the MCO's CEO or CFO. The MCO must submit the certification concurrently with the certified data. The data that must be certified include, but are not limited to, enrollment information, weekly 837 encounter data submissions, and other information required by the Department and contained in contracts, proposals, and related documents.

6.10.1 Quarterly Reports

The MCO must provide the Department with quarterly reports summarizing provider network, utilization, quality, access, EPSDT, and financial data in formats to be specified by the Department, no later than the fifteenth (15^{th}) day of the second (2^{nd}) month following the end of the reporting period.

The quarterly report must provide information on the number of Medically Necessary services contained within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act but not covered under the State Plan.

6.10.2 Grievance and Appeals Reporting

The MCO must provide the Department with quarterly reports documenting the number and types of grievances and appeals, the turnaround times, and other defined metrics, utilizing the required grievances, appeals and denials (GAD) template. Reports must be submitted no later than one hundred five (105) days after the end of the reporting quarter to allow for completion of the ninety (90)-day resolution period and fifteen (15) days to complete report development. The MCO shall submit required files from the GAD universe report within thirty (30) days after submission of the GAD universe report to the Department.

6.10.3 Enrollee Change in Cirucumstance Reporting

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 procedures for notification to the state within five (5) business days of receiving information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including:

1. Changes in the enrollee's residence; and
2. The death of the enrollee.

6.10.4 Enrollee Satisfaction Reporting

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 perform the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult survey, CAHPS child survey, and the CAHPS children with chronic conditions survey using the latest available version of the CAHPS survey template published by the National Committee for Quality Assurance (NCQA). 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 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 September 30th. 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, , 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.

Claims certificates are required from each provider submitting data to the MCO. The MCO must collect and maintain sufficient data to identify the provider who delivers any service(s) or benefit(s) to enrollees. The MCO must require its physicians who provide Medicaid services to have a unique identifier, which must be used in all encounter data submissions. The Rendering and Billing Provider's NPI must be included in the encounter data whenever possible when submitting the required encounter data per 42 CFR 438.242. The MCO must submit all data relevant to the adjudication and payment of claims in sufficient detail to support comprehensive financial reporting and utilization analysis.

The encounter data set will include at least those data elements as specified by BMS or necessary for CMS to provide data at the frequency and level of detail specified by the Secretary of the federal DHHS. This includes, but is not limited to, accurate enrollee and provider identifying information; date of service; procedure and diagnosis codes; allowed, paid, and third party liability (TPL) amounts; claim payment dates and all other elements identified as required in the Encounter Companion Guide.

Complete and accurate encounter data must be submitted no later than thirty (30) calendar days after the date in which the claims were adjudicated (paid, adjusted, voided, or denied). The MCO will submit encounter data files no less frequently than on a biweekly basis. Within ten (10) business days after the end of a payment cycle the MCO is required to generate encounter data files from its claim management system(s) and other system. If there is more than one (1)

payment cycle within ten (10) business days, the encounter data files can be merged and submitted within five (5) business days of the end of the final payment cycle within this period.

The MCO must submit at least ninety-six percent (96%) of all encounter data, including those of Subcontractors, both for the original claim and any adjustment or void within thirty (30) calendar days after the adjudication date.

The MCO will ensure that Subcontractors comply with contract provisions, including ensuring that payment information on the Subcontractors' Encounter Data reflect the date and the amount paid to the provider by the Subcontractor. Subcontractors will be held to the same completeness, accuracy, and timeliness requirement as the MCO for encounter data submissions. The MCO must maintain appropriate systems and mechanisms to obtain all necessary data from its providers and Subcontractors to ensure the encounter data reporting requirements are met.

Along with the encounter data submission, the MCO must submit:

- A detailed summary of the file submission to include total claims and dollars by service category;
- For all payments made to providers related to MCO or Subcontractor claims, the MCO must submit monthly complete Cash Disbursements Journal (CDJ) using the template provided by BMS. The MCO must provide all data elements requested within the CDJ. The MCO must assist BMS in reconciliation of Cash Disbursement transaction amount totals to MCO Paid Amount totals for submitted claims;
- A detailed change log to include specifications for any change in the claims processing systems that has an impact of the representation of the data on the monthly encounter files. Examples of such changes include, but are not limited to, correction and adjustment processing, range and domain of extract variables, values of extract variables, and relationships between extract variables; and
- 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, using procedures outlined in the Encounter Companion Guide. When the BMS or its Fiscal Agent Contractor (FAC) rejects a file of encounter claims, the rejected files must be resubmitted with all of the required data elements in the correct format as outlined in the Encounter Companion Guide by the MCO within thirty (30) calendar days from the date the MCO received the rejected file.

6.10.5.5 Encounter Data Reconciliation

BMS or its Agent will validate encounter claims submissions according to the CDJ provided by the MCO and its applicable Subcontractors. If the MCO or any of its Subcontractors fail to submit complete encounter data, as measured by a minimum completion percentage of ninety-six percent (96%) when encounters are compared to cash disbursements for the MCOs and its Subcontracts, the MCO may be subject to liquidated damages or other available remedies as outlined in Appendix F.

6.10.6 Healthcare Effectiveness Data and Information Set (HEDIS) Reporting

The MCO must report audited HEDIS measures to the Department annually by July 14. Once the MCO performs NCQA's HEDIS Compliance Audit, the audited results must be submitted to the Department upon submission to NCQA. The Department will provide guidance to MCOs regarding which measures must be reported, according to the current version of HEDIS.

6.10.7 National Core Health Care Quality Measures Reporting

The Secretary of the DHHS has identified a set of core health care quality measures for Medicaid-eligible adults and children enrolled in Medicaid and CHIP. The MCO must report annually to the Department results for all identified core adult and child quality measures relevant to the Contract covered services following the technical specifications provided by CMS. Results for the previous calendar year are due on or before September 1st. The MCO must use the most recent technical specifications from CMS, available at www.medicaid.gov, to calculate results.

6.10.8 Financial Reporting

Regular reporting is necessary to assure the ongoing operation and financial integrity of participating MCOs. The MCO must provide financial reports as specified by this Contract. Plans that are in a particularly weak financial position may be required to report more frequently.

1. *West Virginia Offices of the Insurance Commissioner (OIC):* The MCO must submit copies of its quarterly and annual OIC reports, as well as any revisions thereto. The MCO must include applicable OIC reports on the solvency of its intermediaries. These reports are due on the same due dates for reporting to the OIC. Any revisions to a quarterly and/or annual OIC report must be submitted on the same day on which the report is submitted to the OIC.

The MCO must comply with all other financial reporting requirements as outlined in Article III, Section 8.

6.10.9 Electronic Visit Verification

To integrate with the state aggregator solution, the MCO must supply the State's assigned vendor with a daily, full replacement import file containing qualified Service Code *T1000 PRIVATE 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.

6.10.12 Federal Reporting Requirements

The MCO must comply with the following Federal reporting and compliance requirements for the services listed below, and must submit applicable reports to the Department. (See Medicaid Physician Provider Manual for state requirements and procedures):

3. Abortions must comply with the requirements of 42 CFR §441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.
4. Hysterectomies and sterilizations must comply with 42 CFR §441. Subpart F – Sterilizations. This includes completion of the consent form.
5. EPSDT services and reporting must comply with 42 CFR §441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

The MCO must submit yearly statements to the Department each year by October 1st attesting 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.

6.10.13 Annual Report

The MCO must submit its annual report for the prior calendar year to the Department by April 1st. The MCO's first annual report under this contract will be due April 1, 2021. The MCO must also make copies of the annual report available on its website and to its enrollees upon request.

6.10.14 Data Necessary for Drug Rebate Collection

For provider-administered drugs provided under managed care, the MCO must submit to the Department the drug utilization data necessary for the collection of drug rebates in formats and data layout to be specified by the Department, as well as re-submitting encounter data as described by Article III, Section 5.10.5. The data must include, but is not limited to the following for each provider-administered drug claim:

6. A HCPCS code,
7. A HCPCS quantity,
8. A NDC number,
9. The NDC unit of measure, and
10. The NDC quantity.

The MCO shall have policies and procedures for assisting BMS, or the fiscal agent, with the drug rebate resolution process, including rejected or disputed physician-administered drug claims. The MCO must resolve any rebatable encounter rejections or disputes within sixty (60) calendar days from notification of the Department or its designee. The MCO must designate a single point of contact responsible for resolving any disputes or deficiencies resulting in a rejection or labeler dispute. The MCO must engage resources such as pharmacists or pharmacy technicians to ensure compliance with the Federal and State Medicaid Drug Rebate Programs.

The Department may return encounters subject to a rejection or labeler dispute to the MCO for correction, reprocessing, and resubmission. The Department will provide the MCO a monthly Pharmaceutical Rebate Information Management System (PRIMS) encounter rejections report no later than the fifteen (15) calendar days following the end of each month listing all encounters subject to a rejection. The MCO must resolve rebate-eligible encounters on the PRIMS reject 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-six (96%) 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 adult and pediatric outpatient mental health and substance use disorder wait time to access mental health and substance use disorder 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.

The MCO must include in its report submission an explanation of any unfavorable mental health or SUD findings.

6.10.17 Managed Care Program Annual Report (MCPAR)

CMS regulations at 42 CFR § 438.66(e) require states to submit a Managed Care Program Annual Report (MCPAR). The MCO must comply with any reporting requirements mandated by BMS to assist in the completion of the MCPAR prior to submission to CMS. The MCO must submit its annual report on applicable MCPAR questions and data elements to BMS on or before October 31st each year. The format, questions, and data elements will be specified by BMS, with reporting occurring annually.

6.10.18 Other Reporting Requirements

The MCO must submit to the Department all Medicare and private accreditation review reports, findings, and other results from the previous three (3) year period, upon request.

The MCO must comply with any additional reporting requirements mandated by CMS during the course of this contract. The Department will provide additional guidance on specific layouts and frequency.

The MCO must submit to the Department a monthly report on the number of enrollees under age twenty-one (21) receiving PRTF services from in-state and out-of-state providers.

6.11 Telehealth

The MCO must implement and use technology including, but not limited to, telemedicine, telehealth, and telemonitoring services to improve quality and access to care. Use of such technology must be in accordance with Department policy. The MCO must:

1. Promote and employ broad-based utilization of statewide access to HIPAA-compliant telemedicine service systems including, but not limited to, access to TTYs and 711 telecommunication relay services;
2. Follow state guidelines for Telemedicine equipment or connectivity;
3. Follow accepted HIPAA and 42 C.F.R. § 2 regulations that affect telemedicine transmission, including, but not limited to, staff and contract provider training, room setup, and security of transmission lines. The MCO must have and implement policies and procedures that follow all federal and state security and procedure guidelines; and
4. Identify, develop, and implement training for accepted telemedicine practices.

7. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM

The MCO must develop and implement written policies for an ongoing QAPI program for the services it furnishes to enrollees. The QAPI must include several distinct, but interrelated comprehensive strategies and must be designed to achieve, through ongoing measurements and intervention, significant improvement in clinical and nonclinical areas of care that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Such improvements must be sustained over time. QAPI strategies must include:

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.

7.2.1 Areas of Focus

Clinical focus areas include:

1. Primary, secondary, and/or tertiary prevention of acute conditions;
2. Primary, secondary, and/or tertiary prevention of chronic conditions;
3. Care of acute conditions;
4. Care of chronic conditions;
5. High-volume services;
6. High-risk services; and
7. Continuity and coordination of care.

Non-clinical focus areas include:

1. Availability, accessibility, and cultural competency of services;
2. Interpersonal aspects of care, e.g., quality of provider/patient encounters;
3. Appeals, grievances, and other complaints;

4. Critical Incidents Reporting; and
5. Effectiveness of communications with enrollees.

7.2.2 Projects

The MCO must initiate[15] and maintain PIPs that address the focus areas specified above. The MCO must maintain at least three projects at a time. The PIPs may be selected by the Department or required by CMS. In cases where the Department does not specify a project focus, the MCO may select a specific topic within one (1) of the identified focused areas. Project proposals must be approved by the Department and the EQRO prior to project initiation.

The topics should be identified through continuous data collection and analysis; systematically selected and prioritized to achieve the greatest practical benefit for enrollees; and reflect the prevalence of a condition among, or need for a specific service by, the MCO's enrollees based on enrollee demographic characteristics, health risks, and any other special needs.

The MCO must use one or more quality indicators to assess its performance. The quality indicators must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research. Indicators must measure changes in health status, functional status, enrollee satisfaction, or valid proxies of these outcomes. The MCO will assess its performance on its selected indicators by collecting and analyzing reliable data on an on-going basis. The MCO must establish a baseline measure of its performance on each indicator, measure changes in performance, and continue measurement for at least one (1) year after a desired level of performance is achieved. The MCO must annually submit performance 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 or as determined by BMS. Sustained improvement is acknowledged through the documentation and maintenance of improved indicator performance. After improvement is achieved, it must be

---

[15] A project has been initiated when it has proceeded at least to the point of baseline data collection. That is, the MCO has selected a particular aspect of care for performance measurement, identified the statistical indicator or indicators that will be used, and begun the process of collecting the data needed for an initial assessment of its performance on the indicator(s).

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.

The MCO must prepare a CAP within thirty (30) calendar days of identification to correct any significant systemic problems. As actions are taken to improve care, the MCO must monitor and evaluate these corrective actions to assure that appropriate changes have been made, and track changes in practice patterns. The MCO must conduct follow-up on identified issues to ensure that actions for improvement have been effective.

Information resulting from QAPI activities will be used in recredentialing, re-contracting, and/or annual performance evaluation. QAPI activities must be coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of enrollee complaints and grievances. QAPI activities will be linked to other management functions of the MCO, such as network changes, benefits redesign, medical management systems, practice feedback to providers, and patient education and enrollee services.

7.4 Health Information System

In accordance with 42 CFR §438.242(b), the MCO must maintain a health information system that collects, integrates, analyzes, and reports data in compliance with Section 1903(r)(1)(F) of the Act and as necessary to implement its QAPI program. This includes data on enrollee and provider characteristics, as well as on services furnished to enrollees as needed to guide the

selection of PIP topics, and to meet the data collection requirements for these projects, as specified above. The MCO's health information system must accept the MAID generated by the Department for all enrollees for data collection and billing purposes. The health information system must also provide information including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for reasons other than the loss of Medicaid eligibility. The MCO must ensure that information and data received from providers are accurate, timely, and complete by routinely reviewing reported data for accuracy, completeness, logic, and consistency, and by collecting service data in standardized formats to the extent feasible and appropriate. The MCO must make all collected data available to the Department and upon request, to CMS in compliance with Section 6504(a) of the ACA.

The MCO must establish interface(s) and conduct testing that meets all Department-specified interface requirements, including, but not limited to, the following:

- MMIS;
- All additional systems added to the state's Medicaid Enterprise System (MES); and
- Integrated Eligibility Solution (IES), when applicable.

This includes, but is not limited to, sending and receiving electronic data interchange (EDI), which includes the submission of encounter data claims and the receipt of eligibility data.

The MCO should work with the state health exchange during the first six (6) months of the contract to deliver an implementation plan to the Department for a secure enrollee portal electronic health record (EHR) system that includes, but is not limited to:

- Information regarding the program;
- The enrollee's account; and
- A portable health passport EHR for every enrollee that can be accessed by all caregivers and the appropriate Department staff.

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

The MCO must designate a senior official 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.

7.5.5 QAPI Communications

The MCO must establish procedures for formal and ongoing communication and collaboration among the policymaking body and other functional areas of the MCO (e.g., health services management and enrollee services), especially with respect to:

1. Resolving enrollee issues;
2. Authorizing service;
3. Developing practice guidelines;
4. Recredentialing practitioners; and
5. Providing feedback to providers and plan staff regarding performance and enrollee satisfaction surveys.

7.5.6 Annual Evaluation

The MCO must formally evaluate, at least annually, the effectiveness of the QAPI program strategy, and make necessary changes. This annual evaluation must assess both progress in implementing the QAPI strategy and the extent to which the strategy is promoting the development of an effective QAPI program. The evaluation must assess whether activities in the MCO's work plan are being completed on a timely basis or whether commitment of additional resources is necessary. The final report must also include any recommendations for needed changes in program strategy or administration. These recommendations must be forwarded to and considered by the policymaking body of the MCO. The MCO must submit to the Department or its designated contractor a written evaluation of its QAPI program strategy by June 15th of each year.

7.6 MCO NCQA Accreditation

The MCO must achieve or maintain accreditation from the NCQA for their Medicaid lines of business by the beginning of each Contract year. The MCO must keep current accreditation from the NCQA for their Medicaid lines of business. The MCO must adopt strategies to simplify administrative procedures per the NCQA Health Equity Accreditation or Health Equity Accreditation Plus programs. The MCO must provide the Department with the accreditation status reports indicating the MCO evaluation option, evaluation measures, evaluation results, and evaluation length. The accreditation reports must be submitted upon completion of each accreditation survey.

Any new MCO entering into this Contract after July 1, 2023, must apply for accreditation with NQCA no later than nine (9) months from its operational start date in West Virginia. Any new MCO entering into this Contract after July 1, 2023, must become accredited with NQCA within two (2) years of its operational start date in West Virginia. The MCO must provide the Department with the accreditation status reports indicating the MCO evaluation option, evaluation measures, evaluation results, and evaluation length. The accreditation reports must be submitted upon completion of each accreditation survey.

7.7 Performance Profiling

The Department may publish information about MCO performance on a regular basis, identifying the MCO's performance indicators, and comparing that performance to other MCOs 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.

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 Capitation Payments to MCOs

8.2.1 Time and Manner of Payment

The MCO will be "at risk" for the services listed in Contract Appendix A (Description of Covered and Excluded Services) through a capitation payment system. The MCO will be paid a fixed rate PMPM for covered services and will not be permitted to collect any additional premiums from enrollees. The MCO shall also receive a fixed monthly payment for SNS administration that will be separate from the capitation received for medical services, and funded by the Bureau for Social Services (BSS). The Department will automatically make capitation payments to the MCO each month based on membership. The Department expects to process payments on or around the sixteenth (16^{th}) day and make capitation payments on or around the twentieth (20^{th}) day of each month. The MCO must submit a quarterly invoice to reconcile any differences between the capitation payments made by the Department and actual membership, including a narrative explaining any differences. The MCO shall conduct this review and submission of this narrative quarterly, unless otherwise directed in writing by BMS.

The Department is unable to provide a guarantee of payment. The Contract includes a provision that allows the MCO to terminate the Contract for non-payment upon a sixty (60) day written notice. The Department must then remedy the conditions contained in the notice within thirty (30) calendar days following the notice of termination or the MCO may terminate the contract.

The MCO must report to the Department within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

All capitation payments are for a full month and not pro-rated. The enrollment termination date for an enrollee will always be the last day of the month. Capitation rates for full-month members have been adjusted to account for members with partial month enrollment, in which no capitation payment will be made for those partial month members. Capitation payments for the following special cases will be made as described below.

1. **Individuals who age into a different rate cell during the month:** The age of an individual on the first (1st day) of the month is used to determine the capitation rate cell for the whole month. If a person has a birthday in the middle of the month, the appropriate cell change will go into effect the following month.
2. **Individuals who die during the month:** Should an enrollee die during the month, the MCO must inform Department within five (5) business days of the MCO becoming aware of the death. The MCO will receive a capitation payment for that entire month. Any capitation payments paid following the month of the enrollee's death will be recovered from the MCO.
3. **Individuals who are institutionalized for more than thirty (30) calendar days:** If an enrollee has been in a nursing facility or state institution for thirty (30) consecutive calendar days, the MCO must inform the Department immediately. The MCO will receive a capitation payment for that entire month. For the remainder of that month, the MCO will be responsible for all medical costs of the enrollee except the Department will pay the bundled payment to the facility.

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.

8.2.2.2. Annual MLR Examination

BMS will engage a subcontractor to perform an annual examination of the MLR report ("MLR Template") referenced in Section 8.2.2.1. The examination will be conducted in accordance with CFR §438.8, 45 CFR §158.150 and 45 CFR §158.151. The purpose of the examination is to determine whether the MCO is meeting the eighty-five percent (85%) MLR standard. BMS and the subcontractor shall convene an entrance conference with each MCO to review the examination process, documentation requests and time frames. The subcontractor shall provide the MCO with a document request checklist and MLR questionnaire prior to the examination.

An exit conference shall be offered with the MCO to review the draft MLR examination report. The MCO shall execute a certification statement attesting to the accuracy of the MLR examination report.

8.3 Third Party Liability (TPL)

Under Section 1902(a)(25) of the Social Security Act, BMS must take all reasonable measures to identify legally liable third parties and treat third party as a resource of the Medicaid enrollee.

8.3.1 Assignment of Rights

Under this Contract, the MCO shall be the primary pursuer of TPL. As such, the MCO shall exercise full assignment of rights, as applicable, and shall be responsible for making every reasonable effort to determine third parties to pay for services rendered to enrollees under this Contract and cost avoid and/or recover any such liability of the third party.

In exercising the assigned TPL rights, the MCO must comply with W. Va. Code § 9-5-11, as well as all applicable state and federal statutes, regulations, and case law when identifying and collecting third party payments.

The State reserves the right to conduct a supplemental (i.e., come behind) TPL recovery program.

8.3.2 Primary and Secondary Recovery Rights

The MCO has the sole and exclusive responsibility and right to pursue, collect, and retain third party payment for services covered in the Medicaid managed care benefit package for three hundred and sixty-five (365) days beginning from the claims paid date.

After day three hundred and sixty-five (365), the State has the right to conduct supplemental TPL recovery efforts and any funds collected by BMS or its contactor through its supplemental TPL recovery process shall be retained by the State.

An extension of the MCO recovery period may be granted upon request, at the sole discretion of BMS, in cases where TPL has been identified by the MCO, recovery has been pursued within the three hundred and sixty-five (365) recovery window, and the MCO can show good cause for failure to recover the outstanding liability.

MCO capitation payment rates are set in recognition of this dualistic recovery structure.

8.3.3 TPL Recovery

During the initial three hundred and sixty-five (365) day MCO recovery window, the MCO must pursue and require its Subcontractors to utilize or pursue, when available, covered medical and hospital services or payments for Medicaid managed care enrollees available from other public 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 determination related to cost effectiveness and access to care that warrants cost avoidance for ninety (90) calendar days.
4. **Right from the Start (RFTS)** – for claims for RFTS services

8.4 Special Payment Arrangements

8.4.1 Responsibility for Inpatient Care

Medical coverage of services at an inpatient care facility charges is considered to be the responsibility of the entity that the enrollee was enrolled under at the time of the initial inpatient facility admission (e.g., MCO, the Department). Responsibility for medical inpatient care will be assigned accordingly in the following circumstances:

1. **Disenrollment:** For the MCO enrollee receiving inpatient care at the time of disenrollment from managed care, coverage of inpatient facility charges (including charges at a transfer facility, if the enrollee is transferred during the stay, or within a facility) provided after the effective date of disenrollment will be the responsibility of the MCO until the enrollee is discharged. Coverage of all other covered services (including, but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care) provided during the inpatient stay will be the responsibility of the Department as of the effective date of disenrollment from the MCO. In the case of insolvency, the MCO must cover continuation of services to enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.
2. **MCO Transfer:** For the MCO enrollee receiving inpatient care at the time of transfer to another MCO, coverage of inpatient facility charges (including charges at a transfer facility, if the enrollee is transferred during the stay) provided after the effective date of transfer between the MCOs will be the responsibility of the MCO in which the enrollee was enrolled at the time of the admission, until the patient is discharged from the

inpatient facility. Coverage of all other services (including, but not limited to emergency transportation, professional fees during the inpatient stay and outpatient care) will be the responsibility of the MCO that the enrollee transfers to, as of the effective date of the enrollment into another MCO. Long-term acute care facilities compensated on a per diem basis are also excluded from these provisions. The LTAC will bill the MCO for services for each month the enrollee was enrolled with the MCO.

3. **Inpatient Transfer:** For the prospective enrollee receiving inpatient care at the time of enrollment into the MCO and who transfers inpatient facilities as part of the same admission, coverage of inpatient facility charges provided after the effective date of the MCO enrollment will be the responsibility of the Department. If an enrollee is discharged and admitted to another inpatient facility, coverage of all services provided at the inpatient care facility will be the responsibility of the MCO.

   When a MCO enrollee under the age of twenty-one (21) is admitted to an inpatient facility and taken into the Department's custody during the same month, the MCO will assume liability for all services provided for as long as the enrollee remains on the MCO's enrollment roster and the MCO receives a capitation payment. During this time, the MCO must continue to provide all care coordination and service authorizations.

   Article III, Section 8.4.1, Responsibility for Inpatient Care, does not apply to behavioral inpatient and residential care services.

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.

8.4.6 Medicaid Institutions for Mental Diseases (IMD)

IMD means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

The MCO must contract with all accredited IMD facilities in the state of West Virginia.

Each capitation period (i.e., calendar month), the MCO shall be responsible for covering up to fifteen (15) days of inpatient psychiatric treatment in an IMD as an in lieu of service authorized by 42 CFR §438.3(e)(2). BMS will issue the MCO a capitation payment for enrollees aged twenty-one (21) to sixty-four (64) who are admitted for inpatient treatment in an IMD, so long as the facility is a hospital providing psychiatric services and the in lieu of services requirements at 42 CFR §438.6(e) and 438.16(b) are met.

Both voluntary and involuntary commitments are the responsibility of the MCO. Additionally, 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.

If an enrollee twenty-one (21) to sixty-four (64) has a stay(s) that exceeds fifteen (15) days in aggregate in a month, the responsibility of payment for IMD coverage will transfer from the MCO to the Office of Health Facilities (OHF) starting on the sixteen (16th) day of the stay in the month. Once the enrollee's stay(s) exceeds fifteen (15) days in a month, OHF will be responsible for payment through the end of the stay under the following conditions:

- For voluntary patients after fifteen (15) days, medical necessity criteria must be met for payment to be issued by OHF; the MCO must retain the responsibility of determining

medical necessity for the enrollee through the entire length of stay. No payment to the IMD may be issued for voluntary patients stays once medical necessity is not met.

- For involuntary patients, payment may be made by OHF prior to day sixteen (16) if medical necessity criteria are no longer met; however, it is the responsibility of the provider and the MCO to transition the patient to a more appropriate LOC in as timely a manner as possible once this criterion is not met. The State will conduct ongoing reviews of patients with stays beyond the medical authorization period to determine if corrective action is warranted

Regardless of the fifteen (15)-day IMD limit and transfer of payment responsibility, the MCO retains responsibility for determining medical necessity, all non-IMD covered services, care coordination at the appropriate level of service, and all transition and discharge planning during the capitation period. BMS will continue to pay the MCO the monthly capitation rate, regardless of an enrollee's IMD stay. However, if an enrollee does exceed the fifteen (15)-day calendar month limit, then BMS will retroactively adjust the CMS-64 report to only claim federal match for capitation payments on enrollees who did not exceed fifteen (15) days in an IMD.

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 arrangements or procedures that are designed to detect FWA. The procedures must include a method to verify with a sample of enrollees whether billed services were received. The MCO must submit its Medicaid compliance plan to the Department by October 1st each year. The compliance plan must include policies and procedures to prevent, detect, investigate, and report potential FWA incidences as outlined by the Department. Funds misspent due to fraudulent or abusive actions by the organizations or its Subcontractors will be recovered. The MCO, and any subcontractor responsible for coverage of services and payment of claims, must include a Regulatory Compliance Committee (RCC) on the Board of Directors and at the senior management level. The committee must be responsible for overseeing the organization's compliance program and its compliance with the requirements under the contract.

9.1.2 Special Investigations Unit (SIU) and Coordination with the State

In order to facilitate cooperation with the state, the MCO must establish and maintain an SIU, either in-house or by Contract with another entity, to investigate possible acts of FWA for all services provided under the Contract, including those that the MCO subcontracts to outside entities. The MCO and MCO SIU must work with the Department, the Medicaid Fraud Control Unit (MFCU), the Attorney General (AG), CMS, and ACF to administer effective FWA detection and prevention practices. The MCO must take part in coordination activities within the state to maximize resources for FWA issues. The MCO must meet regularly with the Department, the MFCU and the EQRO to discuss plans of action, and attend FWA training sessions as scheduled by the State. MCO reporting procedures and timelines for FWA complaints and outcomes must meet State-established guidelines.

9.1.2.1 Program Integrity Staffing Requirements

The MCO must have at least the equivalent of one (1) full-time, West Virginia-based Program Integrity Professional who is dedicated one hundred percent (100%) to the WV Medicaid program and who can, at a minimum, perform the following duties:

1. Initiate investigations and develop FWA cases for future action.
2. Follow up appropriately on program integrity leads from the Department.

3. Execute and respond to requests for information (RFIs) from the MFCU, including MFCU data requests.
4. Execute and respond to RFIs from the Department, or other State actors.
5. Act as the point of contact for program integrity deconfliction.
6. Participate in West Virginia-based training, task forces, and other relevant meetings.

For initial implementation, the MCO must meet the staffing requirement within ninety (90) days of the contract effective date.

Outside the initial implementation period, the MCO must notify the Department of any absence or vacancy more than thirty (30) days and must include a contingency plan for fulfilling the program integrity requirements during the absence or vacancy.

9.1.2.2 Program Integrity Points of Contact

The MCO must designate one (1) primary and one (1) secondary contact person for all Department Program Integrity and MFCU requests for data, records, or other information. 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.
8. Written policies and procedures that define the appeal right(s) granted to participating providers when a finalized overpayment determination is issued, the duration of those appeal rights, and requirements the requests for appeal must meet to be considered valid. These policies and procedures must be made publicly available.

9.1.3.2 Required Procedures for the Internal Compliance Plan

The MCO's Medicaid compliance plan must also include procedures for:

1. Conducting regular reviews and audits of operations to guard against FWA;
2. Verifying, through sampling or other methods, whether services reimbursed were actually furnished to enrollees, including documenting the results of verification activities;
3. Assigning and strengthening internal controls to ensure claims are submitted and payments are made properly;
4. Educating employees, network providers, and beneficiaries about FWA and how to report it;
5. Effectively organizing resources to respond to complaints of FWA;
6. Establishing procedures to investigate FWA complaints;
7. Establishing procedures for reporting information to the Department; and
8. Developing procedures to monitor service patterns of providers, Subcontractors, and beneficiaries.
9. Conducting appeals of finalized overpayment determinations in response to a valid request for appeal.

9.1.3.3 Training of Senior Management, Employees, and Subcontractors

The MCO and its subcontractors' compliance program must include a system for training and education of the following individuals on the federal and state standards and requirements under the contract:

1. The CEO;

2. The CFO;
3. The organization's senior management; and
4. The organization's employees.

9.1.3.4 Requirement to Monitor Provider and Beneficiary FWA

The MCO must monitor provider fraud for underutilization of services and beneficiary/provider fraud for overutilization of services. Monitoring must include, but is not limited to the following:

1. Identifying provider FWA by reviewing for:
    a. A lack of referrals;
    b. Patterns of self-referral;
    c. Improper coding (upcoding and unbundling);
    d. Billing for services never rendered;
    e. Billing non-covered services as covered services;
    f. Unqualified providers billing for services;
    g. Billing for medically unnecessary services; or
    h. Billing for services with a date of service beyond an enrollee's date of death.
2. Identifying beneficiary FWA by reviewing for:
    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 August 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 calendar month, as noted in Article III, Section 3.1.4 and Appendix D. See also Article III, Section 9.2, and Credible Allegation of Fraud.

The MCO will notify the Department of all incidents of suspected FWA even if it is also referred to an entity other than the Department such as the appropriate licensing and/or disciplinary bodies or other appropriate authorities.

9.1.5 Investigations

The MCO must cooperate and assist the Department or any State or Federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected FWA. The MCO is responsible for investigating possible acts of FWA for all services, including those that the MCO subcontracts to outside entities.

If the MCO identifies that suspected fraud, waste, or abuse has occurred in the Medicaid or WVCHIP programs, based on information, data, or facts, the MCO must immediately notify the BMS Office of Program Integrity (OPI) following the completion of ordinary due diligence regarding a suspected fraud or abuse case. If BMS OPI accepts the case for State investigation, the MCO may not engage in overt investigation efforts other than coordination efforts with the State. The BMS OPI will supply a written notice to the MCO notifying it of the case acceptance status no later than the tenth (10th) business day after the MCO notifies the BMS OPI of the suspected fraud or abuse.

The MCO may proceed with the investigation or payment recovery efforts if the MCO receives a notice from the BMS OPI and/or the MFCU indicating that the MCO is authorized to proceed with a case. Notification that BMS OPI or MFCU does not accept the referral must be deemed authorization for the MCO to proceed with the case. If the MCO has not received a response from OPI after three (3) requests by the MCO, or within ten (10) business days of submission of

referral to OPI, the MCO may proceed with its investigation up to and including recoveries. If the MCO has not received a response from OPI regarding the acceptance status of any subsequent referral by OPI to the MFCU after three (3) requests or within sixty (60) calendar days of the original referral to BMS OPI, the MCO may proceed with its investigation up to and including recoveries.

BMS OPI will request from the MFCU and supply to the MCO, quarterly updates on the current status of all cases where a referral was made by the MCO and accepted for state/MFCU investigation. Upon consolidation, disposition, or closure of any case by the MFCU that was originally referred by the MCO, BMS OPI will request written notice from the MFCU identifying the reason for closure and/or final disposition of the case(s). BMS OPI will provide timely written notice of said information to the referring MCO no later than the next quarterly update.

9.1.6 Prevention and Detection

The MCO must regularly submit encounter data as requested by the Department, as well as other data specified in Article III, Section 6.10 of this contract. All other terms and conditions of the original Purchase of Service Contract will remain unchanged and in full force and effect.

9.1.7 False Claims Act

Pursuant to Section 6032 of the Deficit Reduction Act of 2005, any entity who receives or makes Title XIX (Medicaid) payments of at least $5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries.

9.2 Credible Allegation of Fraud

42 CFR §455.23 requires the State Medicaid Agency to suspend all Medicaid payments to a provider after the Agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause not to suspend payments or suspend payment only in part. The rules governing payment suspensions based upon pending investigations of credible allegations of fraud apply to Medicaid managed care entities.

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. 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 Department or its contractor identifies an overpayment made by the MCO to the provider;
2. The payment occurred outside the grace period, as defined by the Department;
3. The MCO has not previously identified the overpayment via the deconfliction process outlined herein;
4. The MFCU or other law enforcement entity is not pursuing the provider; and
5. The MCO does not collect the full amount of the payments identified as overpaid through audit activities within one (1) year of the date of identification except in the following:
    a. An extended recovery period for a case is approved by BMS;
    b. The identified overpayments become unrecoverable due to the responsible organization filing for chapter 11 bankruptcy; or
    c. The individual provider responsible for the overpaid service becomes deceased,

d. BMS determines, based upon documentation submitted by the MCO, that the MCO has diligently and in good faith made all reasonable efforts to collect the full amount of the overpayment identified and approves closure of the audit activity.
e. The MCO completed a referral to BMS OPI, which was accepted for further investigation.

The Department will send notice to the MCO with all information upon which the overpayment determination was based, along with a demand for payment. The MCO will enter into a payment agreement within thirty (30) calendar days of receiving notice, and effectuate payment within ninety (90) calendar days of notification. Failure to adhere to this process will result in liquidated damages as described in Appendix F. In the event that the MCO is invoiced for the overpayment by the Department, and the MCO recovers the overpayment from the provider, the provider's sole remedy is under the provisions of the provider's contract with the MCO. For provider appeals arising from actions taken pursuant to this section, the MCO must communicate the result of those appeals to the Department within sixty (60) calendar days of the final decision. The Department may only initiate recovery for overpayments within the five (5) years following the date the overpayment was identified.

9.3.2 Department's Right to Collect from Providers

The Department has the right to recover provider overpayments, including those overpayments due to fraud, waste, or abuse, from the provider if:

1. The Department or its contractor identifies an overpayment made by the MCO to the provider;
2. The payment occurred outside the grace period, as defined by the Department;
3. The MCO has not previously identified the overpayment via the deconfliction process outlined herein;
4. The MFCU or other law enforcement entity is not pursuing the provider; and
5. The Department, in its sole discretion, determines it is unable to collect from the MCO.

The Department will send notice to the MCO of its intent to collect from the provider and will initiate recovery actions with the provider. In the event that the Department chooses to exercise its right to collect the overpayment directly from a provider, the MCO assigns to the Department any rights it has to collect overpayments from the provider. Such payments recovered will be retained by the Department. The MCO must advise their providers, via contract provision, addendum, notice or other suitable method, of the State's right to collect overpayments pursuant to an assignment of rights as described in this section. The provider's appeal rights in the event of the Department collecting an overpayment directly from the provider are outlined in the BMS Policy Manual, chapter 800(B).

9.3.3 MCO's Right to Recover Overpayments

The MCO must diligently engage in efforts to facilitate the timely identification and recovery of all payments identified as having been overpaid through audit activities that do not require a referral to the State. Overpayments identified and/or recovered must be reported on the monthly FWA report.

Unless otherwise specified in this contract, when the MCO or its subcontractor identifies overpayments, the may recover and retain those overpayments directly from the providers, 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.

However, if the MCO has not collected the full overpayment amount identified in the referral within one (1) year of notification by BMS, BMS may collect and retain the monies from the provider or the plan which made the overpayment, except when the MCO has requested and been approved to offer an extended recovery period or close an audit activity with identified overpayments outstanding.

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.

9.3.5 Provider Reported Overpayment

In addition to internal processes to identify any overpayments, the MCO must have a process in place for network providers to report receipt of an overpayment. The provider is required to notify the MCO in writing of the reason for the overpayment and return the full amount of the overpayment to the MCO within sixty (60) calendar days after the date on which the overpayment was identified.

9.3.6 Impact on Medicaid MLR and Rate Setting

Pursuant to 42 CFR §438, overpayment recoveries must be deducted from incurred claims when calculating the MLR, and encounter data must be adjusted appropriately for rate setting purposes.

9.3.7 MCO Pre-Payment Review Activities

The MCO must have an effective means by which to conduct pre-payment reviews (PPR) to prevent inappropriate payments to providers where data analysis or investigation suggests the potential for Fraud, Waste, or Abuse, however no clear indices have been established. The MCO must notify the BMS OPI seven (7) days prior to the implementation of any PPR activity. Outcomes and cost savings of pre-payment review must be reported to BMS OPI via monthly reporting.

10. DENTAL SERVICES

10.1 Children's Dental Services Administration[16]

The MCO must provide children's dental services to individuals under twenty-one (21) years of age as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished. The MCO may place appropriate limits on 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.

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 children's 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. Medicaid children's dental services include diagnostic services, preventive treatment, restorative treatment, endodontic treatment, periodontal treatment, surgical procedures and/or extractions, orthodontic treatment, complete and partial dentures, as well as complete and partial denture relines and repairs. Also included are adjunctive general services, injectable medications, and oral and maxillofacial surgery services.

---

[16] The MCO must cover the full scope of the dental services under the EPSDT coverage requirements for enrollees under twenty-one (21).

10.2 MHP Adult Dental Services Administration and Covered Services

The MCO must provide enrollees twenty-one (21) years of age and older with diagnostic, preventive, and restorative dental services, excluding cosmetic services in accordance with WV Policy Chapter 505 Oral Health Services. The MCO must place appropriate prior authorization limits on covered adult dental services on the basis of such criteria as medical necessity or for utilization control, consistent with the terms of this Contract and clinical guidelines. Such 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 coverage limits 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 coverage 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, 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.

10.3 Dental Director

The MCO must have, or require its dental subcontractor to have, a qualified licensed dentist to serve as the Dental Director for the dental benefit. The Dental 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. The Dental Director is responsible for oversight of utilization of covered dental services within the contract. The Dental Director, or his or her designee meeting the qualifications described above, must be available for dental utilization review decisions and must be authorized and empowered to respond to dental clinical issues, utilization review, and dental quality of care inquiries.

10.4 Oral Health Fluoride Varnish Program

The MCO must educate its network providers about the Department Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners, where PCPs may receive a reimbursement for fluoride varnish application. Providers are encouraged to complete the Smiles for Life Curriculum course prior to administering, but are not required to do so.

10.5 Coordination of Care

Pursuant to 42 CFR §438.208, the MCO is responsible for the management of dental care and continuity of care for all affected MCO enrollees. The MCO or the MCO's PCP must urge enrollees to see their dental provider at least once every six (6) months for regular check-ups, preventive pediatric dental care, and any services necessary to meet the enrollee's diagnostic, preventive, restorative, surgical, and emergency dental needs. For enrollees in foster care who have not had a dental screening in over one (1) year, the MCO must escalate the issue to the enrollee's caseworker. For other MHP enrollees the MCO should intervene if an enrollee has not had a dental screening in over one (1) year.

Per Article III, Section 2.2, the MCO's PCP must coordinate care by providing a direct referral to a dentist for children beginning at six (6) months after the first tooth erupts or by twelve (12) months of age as a part of the EPSDT process. Dental screenings are covered for any child under the age of twenty-one (21) years per the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures.

10.6 Continuity of Care for MCO Orthodontic Services

The MCO's reimbursement for children's orthodontic services must cover the entire duration of treatment.

10.7 Continued Care for Active Orthodontia

The MCO must ensure, in conjunction with the Department, continuity of care for active orthodontia cases until care is completed and providers are fully reimbursed. The MCO must pay for orthodontic services not previously reimbursed under the FFS as a part of the global payment fee.

The MCO must allow an enrollee to continue receiving orthodontic services with an existing out-of-network provider.

The MCO must maintain written orthodontic continuity of care records.

11. BEHAVIORAL HEALTH SERVICES

11.1 MCO Behavioral Services Administration

The MCO must provide inpatient and outpatient behavioral services as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services 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 and 42 CFR §438.910(d)(3).

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

---

[17] 42 CFR § 438.210

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 services or that a screen be conducted. Providers must incorporate the EPSDT HealthCheck screening questions into their mental health screening process as a critical means for determining trauma history and any current trauma-related symptoms. The MCO shall provide a quarterly report of all approved and denied mental health screenings and services. Failure to complete a mental health screening for any child not currently receiving mental health services shall result in a liquidated damage, as defined within Appendix F.

11.2 Behavioral Health Director

The MCO must employ or Contract with a qualified West Virginia licensed physician to serve as the Behavioral Health Director for the covered behavioral services. When employed or contracted, the Behavioral Director must be available for behavioral utilization review decisions and must be authorized and empowered to respond to behavioral clinical issues, utilization review, and behavioral quality of care inquiries.

11.3 Behavioral Health Covered Services

The MCO covered behavioral services must be rendered by providers within the scope of their license and in accordance with all State and Federal requirements. Behavioral services include: mental health outpatient services, mental health inpatient services, SUD outpatient services (including but not limited to pharmacologic management and including methadone treatment), targeted case management (TCM), behavioral health rehabilitation and clinic services, psychiatric residential treatment services, and all SUD treatment services provided under the Department's 1115 SUD waiver. The MCO must follow Department FFS policies contained in Chapter 529 of the WV Medicaid Provider Manual for drug screening services.

11.4 Coordination of Care

Notwithstanding internal care coordination of care requirements outlined in Article III, Section 6.3 of this Contract, the MCO's PCP must coordinate the enrollee's health services, as appropriate, with behavioral health providers.

The MCO must initiate care coordination services for enrollees being discharged from crisis stabilization units.

If an enrollee is identified as having a dependence disorder including alcohol, opiate, amphetamine, benzodiazepine, or poly substance, and in need of engagement of treatment, the MCO must assign the enrollee a MCO Care Coordinator, at a minimum, through the duration of the treatment process. MCO Care Coordinators should coordinate with Assertive Community Treatment (ACT) Case Managers when the enrollee requires an intensive and highly integrated approach for community mental health service delivery.

11.5 Adult Inpatient and Residential Care for Behavioral Health

Article III, 8.4.1, Responsibility for Inpatient Care, does not apply to the behavioral inpatient and residential care services. Payment liability for behavioral health inpatient services is assigned as follows:

1. The MCO is not responsible for any payments for inpatient behavioral health services that are covered by FFS;
2. The MCO is responsible for all claims incurred within the inpatient behavioral health treatment settings covered by managed care;
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.

The MCO must provide services in accordance with the BMS Policy Manual, Chapter 503 Licensed Behavioral Health Centers Appendix 503I, with the exception of the following provision: the MCO may not require prior authorization for the first one hundred forty-four (144) units of crisis stabilization. The MCO must provide prior authorizations for crisis management services as expeditiously as the enrollee's condition requires and within a timeframe not to exceed two (2) business days.

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

11.10 Substance Use Disorder (SUD) Services

11.10.1 General Requirements

In response to the opioid epidemic in West Virginia, the Department seeks to enhance SUD prevention and treatment services available to Medicaid enrollees.

11.10.2 SUD 1115 Demonstration Waiver

Building on legislative and health systems activities, the goal is to create a seamless continuum of care to support enrollees in their recovery. The MCO is expected to support the following goals:

1. Improve quality of care and population health outcomes for Medicaid enrollees with SUD;
2. Increase enrollee access to and utilization of appropriate SUD treatment services based on American Society of Addiction Medicine (ASAM®) Criteria;
3. Decrease medically non-emergent and avoidable utilization of high-cost emergency department and hospital services by enrollees with SUD;
4. Improve care coordination and care transitions for Medicaid enrollees with SUD; and
5. Follow the CMS standards and guidelines as stated in the Special Terms and Conditions of the West Virginia approved 1115 SUD Waiver.

The Department has established standards of care for SUD demonstration waiver services that incorporate industry standard benchmarks from the ASAM® Criteria for patient assessment and placement, service, and staffing specifications.

11.10.3 SUD Services Continuum of Care

The MCO will be responsible for a seamless continuum of care for SUD treatment to all West Virginia Medicaid enrollees who meet medical necessity criteria for services. These services include standard SUD services authorized under the West Virginia Medicaid State Plan as well as SUD services authorized under West Virginia's SUD 1115 demonstration waiver. The MCO must follow all standards and criteria adopted by the Department regarding SUD services as outlined in the West Virginia Medicaid Provider Manual, Chapter 504: Substance Use Disorder Services.

11.10.3.1 Medicaid State Plan SUD services

Medicaid State Plan SUD services include:

1. TCM;
2. Naloxone Administration Services;
3. Screening, Brief Intervention and Referral to Treatment (0.5 ASAM® Level of Care);
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

At such time that BMS determines services will be implemented, the MCO must provide for services for enrollees and comply with all programmatic and reporting requirements. Upon request, the MCO must collaborate with BMS in planning for and implementation of these 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;
4. Clinically Managed High Intensity Residential Services (3.5 ASAM® Level of Care);
5. Clinically Managed Residential Withdrawal Management Services;
6. Expansion of Residential Treatment for Medically Complex Individuals;
7. Supported Housing Services;
8. Recovery Related Support Services; and
9. Quick Response Teams (QRTs).

11.10.3.3 Strategy for Opioid Prevention and Treatment

The MCO must have in place a strategy for preventing and treating opioid addiction and improving healthcare for members at risk of or with an opioid and/ or SUD. The strategy should describe how the Vendor will partner with providers to address opioid addiction. The strategy should include, but not be limited to, the MCO's approach to:

- Increasing member engagement and improving care coordination to address early detection of dependence, prevention, treatment, and recovery
- Supporting and promoting access to high-quality addiction and recovery treatment services
- Helping ensure equitable access to treatment and reducing stigma
- Promoting the use of evidence-based treatment
- Participating in meetings with the Office of Drug Control and Policy

Opioid Treatment Program services (methadone only) included in the SUD waiver will be provided through Medicaid FFS. The MCO will be responsible for assisting an enrollee during the admission and discharge transition process for Opioid Treatment Program services.

11.10.3.4 Peer Recovery Support Services

Peer recovery support services are designed and delivered by individuals called Peer Recovery Support Specialists who are in recovery from SUD. These Peer Recovery Support Specialists provide counseling support to help prevent relapse and promote recovery. Services must be provided by appropriately trained staff when working under the supervision of a competent behavioral health professional, as defined by the State. A Peer Recovery Support Specialist must be certified as outlined in the West Virginia Medicaid Provider Manual, Chapter 504. The West Virginia Department-approved training program provides Peer Recovery Support Specialists with a basic set of competencies necessary to perform the peer support function. The Peer Recovery Support Specialist must demonstrate the ability to support the recovery of others from SUD. Similar to other provider types, ongoing continuing educational requirements for Peer Recovery Support Specialists must be in place.

11.10.3.5 SUD Residential Treatment Services

Treatment services delivered to residents of an institutional care setting, including facilities that meet the definition of an IMD, are provided to West Virginia Medicaid enrollees with an SUD diagnosis when determined to be medically necessary by the MCO's utilization staff and in accordance with an individualized service plan (ISP). MCOs are required to contract with all treatment facilities supported through the Ryan Brown Addiction Prevention and Recovery Fund. The MCO's utilization staff, physicians, or Medical Directors will perform independent reviews of assessments to determine the LOC and length of stay recommendations based upon the ASAM® multidimensional assessment criteria.

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 sent out by the Department and the MCO will be notified of the certified providers by the Department.

Contingent on the SUD providers receiving certification from the state, the MCO will credential all SUD providers consistent with the key benchmarks from ASAM® Criteria as set forth in the Medicaid Provider Manual, Chapter 504.

The MCO must meet the SUD provider network standards as outlined in Appendix J.

11.10.6 SUD Provider Training and Education Requirements

SUD providers are responsible for providing training and education to their staff on the ASAM® Level of Care criteria and the application of the ASAM® Criteria in the assessment process. During provider enrollment, the MCO will obtain attestation from the SUD provider that ASAM® Criteria will be applied appropriately by the provider's SUD program staff. As part of the Department's quality monitoring strategy, personnel and clinical records of a sample of the provider network will be reviewed to evaluate if there is appropriate application of and fidelity to the ASAM® Levels of Care and the Medicaid Provider Manual. The Department's ASO contractor for the SUD waiver will perform these retro reviews of providers to ensure SUD program providers are consistently applying ASAM® Criteria throughout an individual's stay and that documentation and personnel records meet established Medicaid standards.

11.10.7 SUD Reporting Requirements

The MCO must comply with all monitoring and evaluation requirements of the SUD waiver.

11.11 Children with Serious Emotional Disorder (CSED) Waiver Services

Children with Serious Emotional Disorder (CSED) is a §1915(c) Medicaid HCBS waiver that provides additional and non-duplicative HCBS beyond what is covered under the state's Medicaid State Plan. The CSED waiver permits the Department to provide an array of HCBS that supports a child/adolescent who would otherwise require institutionalization to remain in their home and community. The waiver intends to reduce the number of children/adolescents residing both in-state and out-of-state in PRTFs and shorten the lengths of stay for children/adolescents who require acute care.

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 been diagnosed with a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) or ICD equivalent that is current at the date of evaluation. The evaluation must state that the serious emotional disorder (SED) has resulted in functional impairment that interferes with or limits the child's role or functioning in family, school, and/or community activities.

The Department contracts with an Administrative Service Organization (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.

Every child/adolescent must have a re-determination of medical eligibility completed at least annually. The anchor date of the child/adolescent'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 denial of waiver eligibility, the final decision will be made by BMS.

11.11.2 Plan of Care (POC) and Child and Family Team (CFT)

The MCO must ensure all enrolled CSED children/adolescents have a CFT which discusses the POC and develops measurable outcomes that guide the child/adolescent toward less intensive services and transitions or graduation from the waiver.

The MCO care manager and wraparound facilitator, in partnership with the CFT inform the child/adolescent and family/legal guardian of all resources that may be included in the POC. All POCs must include at least one CSED waiver service in addition to wraparound facilitation. CSED waiver services emphasize the importance of combining natural supports from the community with professionals to create a POC that reflects the goals that are important to the child/adolescent and family/legal guardian.

The CSED waiver program utilizes the strengths model, which views the child/adolescent and family/legal guardian of the child as the expert on the strengths and needs of the child. These strengths and needs are used to guide POC development in combination with the information gathered during the intake and reassessment. The CFT captures the strengths, needs, preferences, and desired outcomes of the child and decides frequency and duration of services and supports.

The CFT consists of the child/adolescent, family/legal guardian, wraparound facilitator, representatives of each professional discipline, provider and/or program providing services to the child (inter- and intra-agency), and MCO care manager. CFT meetings must be scheduled at times and places that facilitate the inclusion of the child/adolescent and family/legal guardian. The child/adolescent and family/legal guardian may request a meeting of their CFT at any time should needs or circumstances change. The child/adolescent and family/legal guardian determine their level of participation in the POC development, the identification of POC goals, and the designation of POC services and supports.

The wraparound facilitator is responsible for scheduling and coordinating CFT meetings, monitoring the implementation of the POC, and initiating CFT emergency meetings as the needs of the child dictate. Although coordination of the POC process is the responsibility of the wraparound facilitator, development of the POC is the responsibility of the CFT. Participation of the CFT is expected to ensure the process is person-centered.

The wraparound facilitator leads the CFT through development and implementation of a transition plan for adolescents as they reach the CSED waiver's maximum age limit. Beginning around the time the child turns fifteen (15), the CFT's focus is on planning for transition including housing, employment, vocational training or school status, emotional/behavioral health, physical health, and safety. The team will focus on enhancing skills utilizing Medicaid State Plan and waiver services and support the adolescent and family/legal guardian in identifying other services and supports such as SSI benefits. The CFT will also review mental health needs the adolescent may have after their twenty-first (21st) birthday and start the transition process with adult services. Whenever possible, the adult services staff are encouraged to become part of the CFT to help ensure a smooth transition to adult services.

The CFT may determine the child has benefited from waiver enrollment and no longer requires services, at which time discharge planning will begin.

11.11.2.1 POC Timeline

A wraparound facilitator with the chosen wraparound facilitation agency will contact the child/adolescent and family/legal guardian to begin engagement in the POC development process prior to the seven (7) day CFT meeting. During this contact, the wraparound facilitator assures the delivery of CSED enrollment information describing the waiver services, free choice of providers, and how to report abuse and neglect. Additionally, the MCO care manager verifies

that CSED enrollment information has been provided and is clearly understood by the child/adolescent and/or their family/legal guardian.

Within seven (7) days of the CSED waiver intake, a mutually agreed upon date will be set for the initial CFT meeting. The wraparound facilitator will also schedule and administer the CANS instrument for use in development of the annual POC. Although the wraparound facilitator 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 POC development. The POC shall be developed within seven (7) days and the master POC completed within thirty (30) days of intake. The MCO care manager will ensure that the CANS is completed and documented as required by the Department's policy. The signed POC must be distributed to all members of the CFT within fourteen (14) calendar days.

The wraparound facilitator is responsible for facilitating the development of and the subsequent updates to the POC document. The POC must be updated every thirty (30) days or sooner in the case of critical treatment junctures to reflect the child's progress or barriers related to POC goals and objectives and reviewed by the CFT. The POC is also updated when a significant life event is determined by the CFT that may alter the child's/adolescent's existing level-of-care status.

The wraparound facilitator must ensure that a six (6) month progress review is completed. At the child's six (6) month progress review, the ASO will conduct a Child and Adolescent Functional Assessment Scale (CAFAS) / Preschool and Early Childhood Functional Assessment Scale (PECFAS) for children/adolescents who have met less than fifty (50) percent of their goals to determine the child/adolescent's acuity level.

The wraparound facilitator is 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 current service providers. The MCO care manager 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 wraparound facilitator if insufficient.

11.11.3 Role of the MCO Care Manager

The MCO care manager is responsible for coordinating the child/adolescent's overall care and is required to provide integrated care coordination services, including follow-up with the wraparound facilitator, interfacing with the child/adolescent's providers, and reviewing medical records. These activities can be discussed during the child/adolescent's CFT meeting.

The MCO care manager is also responsible for conducting initial assessments, developing care plans in collaboration with the wraparound facilitator and family/legal guardian, monitoring service delivery, and ensuring compliance with HCBS requirements.

The MCO care manager must ensure a wraparound facilitator is assigned to each eligible child/adolescent and enrolled in the CSED waiver. As a safeguard, wraparound facilitation cannot be provided by the same agency providing any other CSED waiver or Medicaid State plan service to the child/adolescent, except when a request for a geographic exception has been granted. Providers may request geographic exceptions for conflict-free case management (Wraparound Facilitator). The MCO care manager will also ensure conflict-free case management is provided by wraparound facilitators and all incident reporting is completed timely and accurately. All crisis plans must be maintained by and accessible to the MCO care manager. CSED waiver providers must be categorized by type of services offered (i.e.,

wraparound facilitation, family therapy) and children/adolescents and their family/legal guardian may choose providers for each category. Child/adolescents and family/legal guardians may change CSED waiver providers at any time with the transfer becoming effective the first day of the month following the request. The child/adolescent and their family/legal guardian will complete a Freedom of Choice form, choosing their wraparound facilitation agency.

The MCO care manager is responsible for engaging the child/adolescent and family/legal guardian in a partnership of shared decision-making throughout the child/adolescent's enrollment in the CSED waiver. Shared decision-making guides the development and implementation of the POC and must be individualized and person-centered. Evaluations are a part of POC development and may include medical, physical therapy, occupational therapy, speech therapy, nutritional, nursing evaluations, and behavior support evaluations in addition to an initial functional assessment administered by the MECA and annual reevaluation by the ASO. The evaluation must state that the SED has resulted in functional impairment that interferes with or limits the child's role or functioning in family, school, and/or community activities.

The MCO care manager is responsible for ensuring that service providers implement the content of the POC and that it is updated every thirty (30) days.

The MCO care manager must review claims history to help ensure children/adolescents are receiving services. This information should be discussed at CFT meetings.

The wraparound facilitator, in collaboration with the MCO care manager, works with the ASO to schedule the child's annual assessment needed to determine continued eligibility for the waiver and enrollment in the MCO. The MCO Care Manager is responsible for ensuring the timely completion of this assessment and that services are delivered appropriately based on the assessment's findings.

11.11.4 Additional Home and Community-Based Services (HCBS)

As appropriate, children enrolled in Mountain Health Promise because of eligibility for the CSED waiver may receive any of the Medicaid State Plan services and CSED waiver services identified in Appendix A as appropriate to meet the child's individual needs, and as defined within Chapter 502 of the BMS Policy Manual. All CSED waiver POC's must include wraparound facilitation and at least one (1) CSED waiver service.

11.11.5 CSED Reporting Requirements

The MCO must comply with all monitoring and evaluation requirements of the CSED waiver, and associated BMS Policy, Chapter 502. The MCO must also comply with all CSED reporting requirements set forth in Appendix D or as otherwise communicated by the Department.

The MCO must comply with the requirements of the WV CSED HCBS Waiver Incident Reporting Guide (IRG). 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 additional resources. Critical incident reporting is crucial to the performance of this agreement and required by 42 CFR § 441.302(a)(6). Timely incident reporting is the responsibility of all parties informed or involved in the event and must be reported to the MCO within 24 hours of occurrence.

The MCO must:

- Develop and maintain policies and procedures to review and track critical incidents and determine whether they represent a single incident or a pattern of incidents with the agency.
- Report incidents to BMS within twenty-four (24) hours of notification.
- Develop and maintain internal incident management system to track critical incidents.
- Develop and maintain policies and procedures for timely critical incident reporting, including required training for failure to report within required time period and corrective action plans for continued failure to report.
- Provide information and resources to all members in the Member Handbook and on the MCO website on how to identify, prevent, and report instances of potential abuse, neglect, or exploitation.
- Receive provider's report of critical incident as soon as possible and within twenty-four (24) hours of witnessing or discovering the incident.
- Monitor providers' investigations to help ensure they are initiated within twenty-four (24) hours of the provider learning of the event and that the completed report is entered into the MCO IMS.
- For suspected abuse and/or neglect, verify that provider has made report to adult protective services (APS) for member over the age of eighteen (18) and child protective services (CPS) for members under the age of eighteen (18).
- Regularly review and analyze incident reports to identify trends regarding members' health and safety and trends regarding provider agencies.
- Inform BMS promptly of any concerns regarding provider agencies and MCO's recommendations and gain support for next steps.
- Analyze claims data for children served under the waiver to determine if current services and acuity levels are appropriate to meet the frequency and intensity of their needs.
- Generate monthly report for BMS of reported allegations of abuse and/or neglect, critical and non-critical incidents, and completed investigations submitted through the MCO IMS, including actions taken to ameliorate the situation and help ensure the health and safety.
- 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.
- Report the incident directly to BMS within twenty-four (24) hours of learning of the incident.

The MCO is required to monitor, collect, and report data on all performance measures as defined by the CSED waiver, such reports include:

- Prior authorization reporting.

- Grievances, appeals, and denials reporting.
- Provider development reporting (includes training, staffing, and provider capacity).
- Individual Service Plan reporting.
- Critical incident and death reporting.
- CSED Waiver Discovery and Remediation Report.
- Provider issues and/or concerns.
- Claims reporting.

11.11.5 CSED Provider Networks

The MCO must comply with all CSED waiver requirements and WV CSED Policy Manual Chapter 502. The MCO is required to provide a network of providers and care coordination services to members enrolled through the CSED Waiver. The MCO must reimburse at least one hundred percent (100%) of the current FFS Medicaid fee schedule to in-network CSED waiver 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 interface and outreach with all CSED waiver approved providers and determine their capacity for new enrollees monthly. The MCO's contracting efforts will include assurances that providers have appropriate and adequate capacity. The MCO must monitor its provider network on a quarterly basis.

The MCO must provide initial and ongoing training to providers and on demand technical assistance.

The MCO must contract with all CSED waiver approved providers within the State, and is required to implement solutions (e.g., Non-Emergency Medical Transportation) to assist CSED children/adolescents in accessing necessary services, including CSED services in areas where there is a lack of provider capacity. The MCO is required to perform prospective enrollee forecasting, in accordance with the CSED waiver enrollment requirements, to ensure that the CSED waiver provider network is continually sufficient to meet the access needs of the population. The MCO is required to perform intensive care coordination efforts to collaborate with its provider network to ensure enrollees have access at the right time for applicable providers.

For CSED members who are discharged from an inpatient stay or residential care setting and no in-network providers are available for CSED services, the MCO must approve authorizations from out-of-network providers to promote continuity of care within seven (7) days. The MCO care manager should coordinate care with the wraparound facilitator to update the POC and ensure that enrollees CSED services are provided in a reasonable time period.

The MCO care manager is required to maintain a roster of available providers who are accepting patients and is required to coordinate with the wraparound facilitator to connect members to available providers within the seven (7) day timeframe from discharge of an inpatient stay or crisis.

If the MCO cannot identify available CSED waiver providers within the State, 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 if 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 CSED waiver service appointment including CSED services in areas where there is a lack of provider capacity.

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).

The MCO must contract with all mobile crisis providers, as defined by BMS, and include provisions in such contracts to address requirements outlined in the BMS crisis intervention services policy.

The MCO must provide outreach and education to enrollees about the availability of these services, including but not limited to, providing notice of availability of the services on the MCO website as well as other materials. The MCO will assist BMS with implementation activities upon request.

11.13 Certified Community Behavioral Health Clinics (CCBHC)

Effective October 1, 2024, The MCO must contract with all CCBHCs and authorize services in accordance with West Virginia §9-5-30 and the BMS Policy Manual, Chapter 503 Licensed Behavioral Health Centers Appendix 503I. The MCO is responsible for payment of CCBHC claims at or above the fee schedule established by the State. The MCO is expected to support CCBHC providers around the changing needs of enrollees. The MCO must provide BMS, BBH, and CCBHCs with regular analytic reports that offer insight into service utilization for enrollees served under the program. The MCO must meet all CCBHC reporting requirements as directed by the State.

12. SOCIALLY NECESSARY SERVICES (SNS)

The MCO is responsible for serving as an ASO for the delivery of SNS under this contract as defined by BSS and outlined within the Department's SNS Utilization Management Manual.

12.1 Contracting

The Department shall retain authority for screening, enrollment and contracting with SNS providers to administer services for youth. The MCO must allow for the authorization of services to any provider approved by BSS. BSS shall provide a monthly enrollment report of all qualified providers permitted to serve enrollees as a validation tool by which to authorize services.

12.2 Invoicing

Invoicing shall remain the responsibility of BSS. The provider must continue to submit invoices directly to BSS for payment. The MCO must assist the provider with validating any information needed for invoicing purposes by providing information as needed (e.g. total authorized units of

a service for the month) upon request of the provider. The MCO must provide such information back to the provider within three (3) calendar days.

12.3 Reporting

The MCO must collect a monthly progress report from the provider for each family served by the 10th day of each month. This document is the same as that to be submitted to the Department. Providers of home studies, clinical reviews and Clinician Administered PTSD Scale (CAPS) reports are not required to submit monthly progress reports, but may only submit their invoice once the home study, clinical review or CAPS report has been provided to the CPS caseworker. The MCO must coordinate with the CPS caseworker and BSS to determine if this deliverable has been met so the Department may issue payment.

The MCO must report monthly to the Department on underserved areas of the State where they believe additional SNS providers should be permitted to enroll to address a gap in care.

12.4 Retrospective Reviews

The MCO must administer retrospective reviews of the SNS providers. Any such review must be conducted within three (3) years of the term of the BSS agreement with the provider. Providers must score at least eighty (80) percent during their retrospective review for each service reviewed. Providers failing to meet eighty (80) percent will be placed on a probation period for each respective service failing to meet that threshold. The MCO must provide a written notice that the probation period is in effect. At the end of the probation period, the MCO must conduct another assessment. If the provider continues to score less than eighty (80) percent for that service, the service will be closed for that provider and the provider will no longer be eligible for 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 contract year one (1), the provider portal must replicate the elements of the existing provider tool for accessing referrals, requesting additional services, and meeting other provider needs. The MCO may develop its own system in parallel for implementation in future contract periods.

12.6 Focus Groups

The MCO must conduct at least four (4) focus groups throughout the year with youth, families and foster parents that reside in the community and utilize SNS. The focus groups 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 focus groups must target, at a minimum, the following five (5) areas:

1. Access
2. Service Delivery
3. Gaps in Support Systems
4. Engagement with System Staff
5. Consumer Knowledge of Services and Supports

The MCO must collaborate with BSS on the questions to be used in the focus groups to ensure the most useful information is being collected.

13. CHILDREN'S RESIDENTIAL TREATMENT FACILITIES/EMERGENCY SHELTERS

13.1 Provider Network

The MCO is required to make all reasonable efforts to contract with all currently enrolled residential treatment facilities. The State shall define for the MCO the category by which each facility falls in alignment with FFPSA.

13.2 Qualified Residential Treatment Program (QRTP)

A QRTP must be a program that:

1. Has 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 through completion of the required thirty (30) day assessment (described below) of the appropriateness of the QRTP placement;
2. To extent appropriate, and in accordance with the child's best interests, facilitates participation of family members in the child's treatment program;
3. Facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child;
4. Documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained;
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
2. Why the recommended placement in a QRTP is the setting that will provide the child with the most effective and appropriate level of care in the least restrictive environment and how that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child (Section75A(c)(1) of the Social Security Act).

13.2.2 QRTP Court Review

Within sixty (60) days of the start of each placement in a QRTP, a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or an administrative body appointed or approved by the court, independently, must:

1. Consider the required thirty (30) day assessment of the appropriateness of the QRTP, and documentation made by the qualified individual conducting the assessment;
2. Determine whether the needs of the child can be met through placement in a foster family home or, if not, whether placement of the child in a QRTP provides the most effective and appropriate level of care for the child in the least restrictive environment and whether that placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child; and
3. Approve or disapprove the placement. Such approval or disapproval must be documented in the case plan (Section 475A(c)(2) of the Social Security Act).

The MCO is required to work with the court system as needed to complete the review and ensure coordination of the child's care if transitioned to a different placement.

The MCO shall establish communications with the judicial system to help ensure the services being ordered for the child are in the child's best interest and medically and/or socially appropriate. This communication should include developing, maintaining, and providing a list, at minimum, at the regional level of all services and placement options available to the court. This relationship should also include being available to provide training and technical services to the court in formal settings as well as one-on-one to assist in understanding the various treatment and placement options available and how to determine the best option.

The MCO shall inform the court of alternative services that best meet the child's needs, as deemed appropriate by the Department. This should include, at minimum, providing a written report to the attorney representing the child and the child's caseworker in any situation where a child is at risk for a substantial change to their placement needs.

13.2.3 Other FFSPA Requirements

The MCO must have procedures in place to ensure that foster children are not inappropriately diagnosed with mental and behavioral health disorders, medical fragility or developmental disabilities for the sole purpose of procuring a placement in a non-family setting such as a residential facility or hospital.

If a title IV-E agency places a child in a QRTP for more than twelve (12) consecutive months, or eighteen (18) non-consecutive months, or, in the case of a child who has not attained age thirteen (13), for more than six (6) consecutive or non-consecutive months, the title IV-E agency must submit to HHS:

- 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.

16. DELEGATION

The MCO oversees and is accountable for any functions or responsibilities that are described in this Contract that are delegated to other entities; and must have in place policies and procedures for effectively assigning and monitoring activities to those entities. All delegated functions must have a written agreement between the MCO and delegated entity, specifying the delegated activities and reporting responsibilities of the entity and providing for revocation of the delegation or other remedies for inadequate performance. The MCO must evaluate the entity's ability to perform the delegated activities prior to delegation, monitor the entity's performance on an ongoing basis, and formally review performance at least annually. If the MCO identifies deficiencies or areas for improvement, the MCO and the entity must take corrective action. If the MCO delegates selection of providers to another entity, the MCO must retain the right to approve, suspend, or terminate any provider selected by that entity.

17. EMERGENCY AND DISASTER DECLARATION

The MCO in good faith will fully execute any addendum, and adhere to any memorandum, directive, order, reporting requirement or other publication by BMS setting forth necessary measures implemented by BMS related to any State, federal or local emergency in order to ensure that:

- The Medicaid program continues to operate efficiently;

- Covered services are delivered to enrollees in a timely and effective manner;
- Providers receive funds needed to continue to operate and provide needed services to enrollees (assuming the funding is supported by proper legal authority); and
- All other public health concerns related to such emergency which can be addressed by Medicaid in cooperation with the MCOs in a manner consistent with State, federal and local laws are sufficiently addressed.

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, Office of Managed Care

Date: 6/7/25

State of West Virginia, Department of Administration Purchasing Division

Signature: Tara Lyk

Printed Name: Tara Lyk

Title: Buyer Supervisor

Date: 7/10/25

Aetna Better Health of West Virginia

Signature:

Printed Name: Todd R White

Title: CEO

Date: 6-6-25

APPENDIX A: DESCRIPTION OF MCO MEDICAL, BEHAVIORAL HEALTH, AND SOCIALLY NECESSARY SERVICES (SNS) COVERED AND EXCLUDED SERVICES

The following charts present an explanation of the medical, behavioral, dental services, and Children with Serious Emotional Disorder (CSED) Home and Community Based Services (HCBS) which the MCO is required to provide and SNS delivered through the MCO as an Administrative Services Organization (ASO). However, the Medicaid and BSS State Plans, the CSED HCBS waiver, and policy manuals are the final sources for defining these services. The MCO should refer to the Medicaid provider manual and BSS utilization management manual available on the Department website for an explanation of service limitations. The MCO must promptly provide or arrange to make available for enrollees all Medically Necessary services listed below and assume financial responsibility for the provision of those services covered by WV Medicaid. Please note that these charts, which list the definitions of services provided under the fee-for-service (FFS) Medicaid program, are provided as a reference for the MCO. The MCO is responsible for determining whether services are Medically or Socially Necessary and whether the MCO will require prior approval for services.

The following charts present the covered services under this contract.

Table A-1: MCO Covered Medical Services

Row	Medical Service	Definition	Scope of Benefit	Limitations on Services
1	Ambulatory Surgical Center Services	Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, as well as private practitioners.	Nursing, technicians, and related services. Use of the facilities where surgical procedures are performed; drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure. Materials for anesthesia.	Physician services; lab & x-ray; prosthetic devices; ambulance; leg, arm, back, and neck braces; artificial limbs and DME are excluded.

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
6	Early and Periodic Screening, Diagnoses and Treatment (EPSDT)	Early and periodic screening, treatment, and diagnostic services to determine psychological or physical conditions in enrollees under age twenty-one (21). Based on a periodicity schedule. Includes services identified during an interperiodic and/or periodic screen if they are determined to be medically necessary.	Health care, treatment, and other measures to correct or ameliorate any medical or psychological conditions discovered during a screening. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve a child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.	Limited to individuals under age twenty-one (21).
7	Emergency Shelter Services	Services provided by an emergency shelter provider.	All emergency shelter providers and services.	NA
8	Family Planning Services & Supplies	Services to aid enrollees of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy.	All family planning providers, services, and supplies.	Sterilization is not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Treatment for infertility is not covered.

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. Gender affirmation surgeries is a service court ordered for BMS to cover and subject to change with legislative action.	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
12	Hospice	In-home care provided to a terminally ill individual as an alternative to hospitalization.	Nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment (DME), drugs, biologicals, home health aide, and homemaker.	Must have physician certification that enrollee has a life expectancy of six (6) months or less. Enrollees age twenty-one (21) and over waive right to other Medicaid services related to the treatment of terminal illness.
13	Hospital Services, Inpatient	Hospital services provided for all enrollees on an inpatient basis under the direction of a physician.	All inpatient services, including bariatric surgery, corneal transplants and long-term acute care (LTAC).	Excludes those adults in institutions for mental diseases. Excludes behavioral health inpatient stays with a DRG of 425-433 or 521-523 or MS-DRG 880-887 or 894-897. Unlimited medically necessary days based on diagnosis related groups. Transplant services must be in a facility approved as a transplant center by Medicare and prior authorized by Medicaid.
14	Hospital Services, Outpatient	Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service.	Preventive, diagnostic, therapeutic, all emergency services, or rehabilitative medical services.	Services not generally furnished on an inpatient basis by most hospitals in the state. Only technical component of certain services.

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
19	Physician Services	Services of a physician to an enrollee on an inpatient or outpatient basis.	Services are provided within the scope of medical practice of an MD or D.O. Includes medical or surgical services of a dentist, medical services related to the treatment of substance abuse, and fluoride varnish services. Physician services may be delivered using telehealth.	Certain procedures may have service limits or require prior authorization. Fluoride varnish services may only be provided to children ages six (6) months to three (3) years.
20	Podiatry Services	Foot care services.	Treatment for acute conditions, i.e. infections, inflammations, ulcers, bursitis, etc. Surgeries for bunions, ingrown toenails. Reduction of fractures, dislocation, and treatment of sprains. Orthotics.	Treatment of children limited to acute conditions. Routine foot care treatment for flat foot, and sublucations of the foot are not covered.
21	Private Duty Nursing	Nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by hospitals or skilled nursing facilities.	Twenty-four (24) hour nursing care if medically necessary.	Prior approval may be required. Limited to children under twenty-one (21) years of age.
22	Prosthetic Devices and Durable Medical Equipment	Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury.	Medically necessary supplies, orthotics, prosthetics, and DME.	Certain orthotics, prosthetics, and DME require prior approval. Certain procedures have service limits. Medical supplies and durable medical equipment in nursing facilities and ICF/MRs are covered in the per diem paid to these providers. Customized special equipment considered.

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.

Row	Medical Service	Definition	Scope of Benefit	Limitations on Services
28	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 services.	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.
29	Vision Services	Services provided by optometrists, ophthalmologists, surgeons providing medical eye care and opticians. Professional services, lenses including frames, and other aids to vision. Vision therapy.	Children-exam, lenses, frames, and needed repairs.	Adults limited to medical treatment only. Prescription sunglasses and designer frames are excluded. First pair of eyeglasses after cataract surgery. Contact lenses for adults and children covered for certain diagnosis.

Table A-2: MCO Covered Dental Services

Row	Dental Service	Definition	Scope of Benefit	Limitations on Services
1	Dental Services (Adult)	Services provided by a dentist, orthodontist, or oral surgeon.	1) Emergency procedures to treat fractures, reduce pain, or eliminate infection and; 2) Diagnostic, preventive, and restorative services.	Adult coverage has a $2,000 per two (2) fiscal year (July 1 – June 30) maximum benefit. Services classified as cosmetic are not covered.

Row	Dental Service	Definition	Scope of Benefit	Limitations on Services
2	Dental Services (Children)	Services provided by a dentist, orthodontist or oral surgeon or dental group to children under the age of twenty-one (21).	Emergency and non-emergency: surgical, diagnostic, preventive, and restorative treatment, periodontics, endodontics, orthodontics, prosthodontics, extractions, and complete or partial dentures.	Limited to individuals under age twenty-one (21).

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.

Row	Behavioral Service	Definition	Scope of Benefits	Limitations on Services
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.
4	Hospital Services, Inpatient – Behavioral Health and Substance Abuse Stays	Inpatient hospital services related to the treatment of mental disorders or substance abuse disorders.	Inpatient hospital services related to the diagnosis, evaluation, and treatment of behavioral health or substance abuse disorders.	NA
5	Inpatient Psychiatric Services for Individuals Under Age Twenty-One (21)	Inpatient psychiatric facility services furnished at a psychiatric hospital or a distinct part psychiatric unit of an acute care or general hospital under the direction of a physician for individuals under age twenty-one (21).	Active treatment of psychiatric condition through an individual plan of care including post discharge plans for aftercare. Service is expected to improve the enrollee's condition or prevent regression so the service will no longer be needed.	Certification must be made prior to admission that outpatient behavioral health resources available in the community did not meet the treatment needs of the enrollee. Pre-admission and continued stay prior authorization.

Row	Behavioral Service	Definition	Scope of Benefits	Limitations on Services
6	Drug Screening	Laboratory service to screen for presence of one or more drugs of abuse.	Screening ordered by the treating practitioner that is deemed medically necessary and reasonable within commonly accepted standards of practice. Results are intended to alter patient management decisions. Full scope of benefits detailed in WV Provider Manual, Chapter 529.	Standing orders must be individualized for each enrollee and updated every thirty (30) calendar days; drug screenings in excess of twenty-four (24) per calendar year are subject to prior authorization. All limitations are detailed in WV Medicaid Provider Manual, Chapter 529.2.
7	Substance Use Disorder (SUD) Services	TCM and physician-supervised medication and counseling services provided to treat those with a SUD.	Comprehensive SUD state plan and waiver services listed in Article III, Section 11.10	Opioid Treatment Program services included in the SUD waiver will be provided through Medicaid FFS.
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 Refer to Table A-5 and Section 11.11.	To be defined, pending approval by CMS. Refer to Table A-5 and Section 11.11.

* 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.	
3	ICF/MR-Intermediate Care Facility for the Mentally Retarded	Community based services for the mentally retarded and those with related conditions.	Services provided both in and out of a group living facility which include but are not limited to: physician services, nursing services, dental, vision, hearing, laboratory, dietary, recreational, social services, psychological services, habilitation, and active treatment	Services are provided based on a plan of care developed by an interdisciplinary team headed by a physician. Enrollee must be certified as needing ICF/MR level of care by physician and psychologist. Limited to the first thirty (30) calendar days.
4	Nursing Facility Services	Facility based nursing services to those who require twenty-four (24) hour nursing level of care.	Full range of nursing, social services, and therapies.	Not covered.

Row	Medical Service	Definition	Scope of Benefits	Limitations on Services
5	Personal Care Services	Medically necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by a registered nurse. These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis.	Services include those activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks.	Room and board services, services which have not been certified by a physician on a Personal Care Medical Eligibility Assessment (PCMEA) or are not in the approved plan of medically necessary care developed by the registered nurse, hours that exceed the sixty (60) hours per member per month (PMPM) limitation that have not been prior authorized, services provided by an enrollee's spouse or parents of a minor child, and supervision that is considered normal childcare.
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.

Row	Medical Service	Definition	Scope of Benefits	Limitations on Services
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.
9	Organ Transplant Services	Transplantation of organs and tissues	Organ transplant services are covered when considered generally safe, effective, and medically necessary, and when no alternative medical treatment as recognized by the medical community is available. The transplant must be utilized for the management of disease as a recognized standard treatment in the medical community and must not be of an investigational or research nature and must be used for end-stage diseases, not as prophylactic treatment.	Corneal transplant services are covered under managed care, not FFS.

Row	Medical Service	Definition	Scope of Benefits	Limitations on Services
10	Substance Use Disorder (SUD) Services	Physician-supervised daily or several times weekly opioid agonist medication and counseling services provided to maintain multidimensional stability to those with severe opioid use disorder.	Opioid Treatment Program services (methadone only)	Must be provided in a Department-licensed methadone clinic and in accordance with ASAM® criteria.
11	Transportation, Non-emergency	Routine medical transportation to and from Medicaid covered scheduled medical appointments.	Includes transportation via multi-passenger van services and common carriers such as public railways, buses, cabs, airlines, and private vehicle transportation by individuals. Ambulance services as appropriate	Prior authorization by BMS is required for multi-passenger van services. Prior authorization by county Department staff is required for transportation by common carriers.
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	Assistive equipment refers to an item or piece of equipment that is used to address the needs that arise because of a serious emotional disorder.	The equipment should increase, maintain, or improve functional capabilities of the child/adolescent, assist them to remain in the home and/or community and avoid an out-of-home placement.	Up to one thousand dollars ($1,000.00) per plan of care year. In combination with Specialized Therapy.
2	Wraparound Facilitation	Wraparound facilitation ensures and coordinates a comprehensive set of supports, resources, and strategies for each child/adolescent and family/legal guardian (as applicable). They work closely with service providers to ensure that CSEDW services and clinical treatment modalities augment each other for optimal outcomes. The wraparound facilitation will lead the CFT through engagement and team preparation, initial plan development, plan implementation, and transition. This includes the development and implementation of a transition plan for adolescents who will reach the waiver's maximum age limit.	Wraparound facilitation is a service provided at two levels, moderate and high acuity. Each child/adolescent will be assigned to an acuity tier. The acuity tier determines a per-member per-month (PMPM) rate for the service. The child/adolescent CAFAS/PECFAS score will be used to determine acuity and help inform the wraparound facilitator of appropriate contact care coordination activities. A Moderate acuity is defined as a CAFAS/PECFAS score of 90 – 130. High acuity is defined as a CAFAS/PECFAS score of 140 or higher.	Up to twelve (12) units per plan of care year as a PMPM rate. Caseloads capped at fifteen (15) members per case manager.

Row	Service	Definition	Scope of Benefits	Limitations on Services
3	Community Transition (Ages 18-21)	Non-recurring set-up services/expenses for individuals ages eighteen (18) to twenty-one (21) who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses.	Allowable expenses are those necessary to enable a person to establish a basic household but do not cover room and board.	Up to three thousand dollars ($3,000) for a one-time transition period. A transition period can last up to six (6) months.

Row	Service	Definition	Scope of Benefits	Limitations on Services
4	Independent Living/Skills Building (Ages 15-21)	Independent living/skills building services focus on empowering the adolescent to attain or maintain their maximum potential and shall be coordinated with any needed therapies in the individual's Plan of Care, such as physical, occupational, or speech therapy. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice. Services are furnished consistently with the child/adolescent's Plan of Care. Independent living/skills building services will facilitate the adolescent's achievement of their goals of community inclusion and remaining in/returning to their home.	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 one hundred sixty (160) units per calendar week in combination with job development and supported employment.

Row	Service	Definition	Scope of Benefits	Limitations on Services
5	Supported Employment (Ages 18-21)	Ongoing support services for members ages eighteen (18) to twenty-one (21) who, because of their SED, need intensive support to obtain and maintain employment in an integrated, competitive work setting, compensated at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without SED. Services may include negotiation with prospective employers, job coaching, transportation, and other workplace supports that enable the member to be successful in integrating into the job setting.	Services may include negotiation with prospective employers, job coaching, transportation, and other workplace supports that enable the member to be successful in integrating into the job setting.	Up to on hundred sixty (160) units per calendar week in combination with independent living/skills building and job development.

Row	Service	Definition	Scope of Benefits	Limitations on Services
6	Family Therapy	Family therapy consists of counseling and training services for the child/adolescent and family/legal guardian provided by a mental health professional. This service includes trauma-informed individual and family therapy. It should assist the child/adolescent and family/legal guardian to acquire the knowledge and skills necessary to understand and address the specific needs in relation to their serious emotional disorder and treatment, such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the child/adolescent's symptom/behavior management.	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 eight (8) units per day, approximately fourteen (14) hours per week (fifty-six (56) units/week).

Row	Service	Definition	Scope of Benefits	Limitations on Services
7	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; providing education to the parent/legal representative regarding their child's mental illness; coaching, supporting, and encouraging new parenting techniques; helping parents/legal representatives learn new parenting skills specific to meet the needs of their child; participating in family activities that support parents/legal representatives in applying specific and on-the-spot parenting methods in order to change family dynamics.	Up to two (2) hours per day (Eight (8) units per day), approximately fourteen (14) hours per week (fifty-six (56) units/week). All services are person-centered and the established service limits may be exceeded when medical necessity is established.

Row	Service	Definition	Scope of Benefits	Limitations on Services
8	Job Development (Ages 15-21)	Provides learning and work experiences, including volunteer work and personal care activities, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.	Job Development should enable each member to attain the highest level of work in the most integrated setting and with the job matched to the member's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.	Up to forty (40) hours per week. In combination with Independent Living/Skills Building and Supported Employment. Services are expected to occur over a defined period of time that does not exceed one (1) year and have specific outcomes to be achieved, as determined by the member and his/her Child and Family Team (CFT) through an ongoing Plan of Care (POC) process. Members receiving Job Development must have employment-related goals in their POC; the general habilitation activities must be designed to support such employment goals.

Row	Service	Definition	Scope of Benefits	Limitations on Services
9	Transportation	Services offered to enable members with SED to be transported to and from local, public community locations for services specified by the individual's service plan.	This service is offered in addition to Medicaid medical transportation required under 42 CFR §431.53 and transportation services under the Medicaid state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the CSED waiver are offered in accordance with the' individual's service plan.	Unit = one (1) mile; up to eight hundred (800) miles per month nine thousand six hundred (9,600) miles per year). All services are person-centered and the established service limits may be exceeded when medical necessity is established.
10	Respite Care (In and Out-of- Home)	Services provided to temporarily 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 in 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.	Unit = fifteen (15) minutes; Up to twenty-four (24) days per year in combination with In-Home Respite Care. All services are person-centered and the established service limits may be exceeded when medical necessity is established..

Row	Service	Definition	Scope of Benefits	Limitations on Services
11	Peer Parent Support	Services designed to offer support to the parent/legal representative/foster parent of the member with SED. The services are geared toward promoting parent/legal representative/foster parent empowerment, enhancing community living skills, and developing natural supports.	This service connects the parent/legal representative/foster parent with a parent(s) who are raising or have raised a child with mental health issues and are personally familiar with the associated challenges.	Unit = fifteen (15) minutes; Up to two (2) hours/week (Eight (8) units/week), approximately eight (8) hours/month (thirty-two (32) units/month).
12	Extended Professional Services: 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.	Unit is one dollar ($1). Up to one thousand dollars ($1000) per service plan year in combination with Assistive Equipment. If this service is not provided by the state plan or private insurance, then members can access these services through this waiver using up to one thousand (1000) units (one thousand dollars) ($1000) per Plan of Care service year; Specialized Therapy and Assistive Equipment share this source of funding.

Table A-6: Covered SNS Delivered Through the ASO

SNS Services CATEGORY	SNS	DEFINITION	SCOPE OF BENEFITS	LIMITATION ON SERVICES
CPS Family Support Services	Refer to BSS utilization management manual available on the Department website for an explanation of the scope of benefits and service limitations.			
CPS Family Preservation Services				
CPS Foster Care Services				
Chafee Foster Care Independence Program				
CPS Reunification Services				
CPS Adoption Preservation Services				
Youth Services Family Preservation Services				
Youth Services Foster Care Services				
Youth Services Chafee Foster Care Independence Program				
Youth Services Reunification Services				

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

(under a separate cover)

APPENDIX C: MARKETING AND MEMBER MATERIALS POLICIES

Legal Authorities

MCO marketing materials, and all other member materials used by the MCO under the MCO Contract must comply with the requirements of Federal law, including but not limited to 42 U.S.C §1396u-2, and 42 CFR §438.104, and 42 CFR §438.10. Additionally, such materials must also comply with terms of the MCO Contract, including but not limited to any appendices, supplements, or written guidance issued by BMS and/or its agent(s), collectively known as the Marketing and Member Materials Policies.

The Marketing and Member Materials Policies contained in this MCO Contract, and in any appendices, supplements, and/or written guidance may be amended by BMS at any time. The MCO will be notified of any such amendments or changes in writing.

All Marketing and Member Materials Policies are applicable to the MCO, its agents, subcontractors, providers, and any individual, organization, or entity connected to the MCO's marketing or enrollee communications activities, whether paid or unpaid (e.g., volunteers).

MCO Marketing and Member Material Submissions

The MCO must follow requirements for submission of marketing materials to BMS for review and approval as required in Article III, Section 3.1.2 of this contract.

Any other MCO materials submitted for BMS approval will be reviewed within forty-five (45) calendar days of submission. As soon as possible after submission, BMS will issue a written review decision to the MCO.

Other enrollee materials that require BMS review and approval prior to distribution include, include but are not limited to:

1. Enrollee Handbook;
2. Member ID Card;
3. Provider Directory;
4. Enrollee Notices; and
5. Other enrollee materials identified by the Department.

The MCO agrees to engage only in marketing activities that are pre-approved in writing by the Department.

General enrollee health education brochures and enrollee health education materials do not require approval from the Department.

1. Health education includes information about programs, services or promotions designed or intended to advise the MCO's enrollees about issues related to health lifestyles, situations that affect or influence health status, behaviors that affect or influence health status or methods of medical treatment.
2. Enrollee health education materials are designed, intended, or used for health education or outreach to the MCO's enrollees. Such materials produced by a source other than the MCO and which do not include any reference to the MCO do not require review and approval.

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,

postcards, flyers, mailers, manuals, booklets, and non-traditional printed materials. Additionally, the outside of material packaging must not contain information or text that identifies the addressee as a Medicaid recipient.

Marketing Policies

The MCO may conduct general advertising that does not specifically solicit the Medicaid population for enrollment.

A. Approved Marketing Practices

The list of approved Marketing practices is not intended to be exhaustive. The following list is applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. The content of all MCO marketing materials—whether taking written, printed, digital, telephonic, or any other form, and regardless of transmission or distribution method, and regardless of authorship or creator must be pre-approved in writing by BMS.
2. The content of MCO marketing materials must be culturally appropriate and accessible for all enrollees and potential enrollees;
3. Terms such as "choose," "pick," "join," etc. are allowed in marketing materials as long as the Enrollment Broker contractor's telephone number is included;
4. The MCO may send plan specific materials to potential enrollees at the potential enrollee's request; The content of such mailings must be approved by BMS prior to distribution;
5. The MCO may only provide plan specific information via telephone during incoming calls from potential enrollees; The MCO may return telephone calls to potential enrollees only when requested to do so by the caller; The content of such call scripts must be approved by BMS prior to distribution;
6. The MCO may respond to direct questions from potential enrollees with accurate information during such telephone calls;
7. The MCO may survey their former and current enrollees;
8. The MCO may provide Gifts approved by BMS to encourage current enrollees to participate in the MCO surveys;
9. The MCO may distribute materials and information that purely educate its enrollees on the importance of completing the State's Medicaid eligibility renewal process in a timely fashion; and
10. At BMS' approval, the MCO may provide information about a Qualified Health Plan (QHP) to potential enrollees who could enroll in such a plan as an alternative to the Medicaid managed care plan due to a loss of Medicaid eligibility or to potential enrollees who may consider the benefits of selecting an Medicaid managed care plan that has a related QHP in the event of future eligibility changes. Such information may not be included within marketing materials.

B. Prohibited Marketing Practices

An MCO engaging in prohibited Marketing practices listed below will be in violation of the MCO Contract and at a minimum, be subject to the remedies available under the MCO Contract.

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;

21. Using marketing agents who are paid solely by commission;
22. Posting MCO-specific, non-health related materials or banners in provider offices;
23. Conducting potential enrollee orientation in common areas of providers' offices;
24. Allowing providers to solicit enrollment or disenrollment in an MCO or distribute MCO-specific materials at a Marketing activity (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.);
25. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying Department's contractors or Subcontractors to send plan specific materials to potential enrollees;
26. Referencing the commercial component of the MCO in any Marketing materials;
27. Discriminating against an enrollee or potential enrollee because of race, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to enrollees with certain diagnoses;
28. Assisting with Medicaid MCO enrollment form;
29. Making false, misleading, or inaccurate statements relating to services or benefits of the MCO or Medicaid program, or relating to the providers or potential providers contracting with the MCO; and
30. Direct Mail Marketing to potential enrollees.
31. Failing to provide an opt-out option in SMS/text message materials.

Social Media Marketing Practices

In addition to all marketing requirements outlined in the MCO Contract, the MCO must comply with the social media Marketing practices as outlined below.

A. Social Media Marketing Guidelines

The following list is applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. At the Department's approval, the MCO may partake in forms of social media advertising (i.e., Twitter, Facebook, Instagram);
2. At the Department's approval, the MCO may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by the Department prior to distribution;
3. The MCO may post MCO Medicaid events on social media sources. The content of such posts must be approved by the Department prior to posting;
4. The MCO may post general non-advertising information regarding MCO activities. The content of such posts does not require Department's prior approval; and

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:

1. Acknowledge receipt, in writing, within one (1) business day from the date of the receipt of the alleged violation.
2. Begin investigation of the alleged violation and complete investigation within fourteen (14) calendar days from the date of the receipt of the alleged violation.
3. Analyze the findings of the investigation and report findings to the Department.

Gifts for Potential Enrollees

The MCO may provide promotional gifts valued at or under fifteen dollars ($15) per individual gift and no more than a cumulative annual value of seventy-five dollars ($75) to potential MCO enrollees. The MCO may distribute promotional gifts valued at more than fifteen dollars ($15) to current enrollees only. A gift worth fifteen dollars ($15) or less must be based on the retail purchase price of the gift item. The MCO must not provide gifts to providers for the purpose of distributing them potential enrollees, unless such gifts are placed in the providers' office common areas and are available to all patients.

Gifts for Current Enrollees

The MCO may solicit its current enrollees for participation in MCO health-related activities or MCO surveys, as identified by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG).

The MCO may provide gifts valued at two hundred dollars ($200) or less per enrollee per gift to encourage enrollee attendance or participation in MCO health-related activities or MCO surveys. Enrollee gifts may not be converted to cash.

The MCO must not exceed the total annual limit of three hundred fifty dollars ($350) per each enrollee for all gifts. The Department must provide prior approval of all monetary and non-monetary compensation provided to enrollees in exchange for participating in any MCO activities.

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
QAPI CAP				X	Within thirty (30) calendar days of identification of systemic problem
CAHPS Enrollee Survey Analysis, Action Plan and Evaluation			X		Annual analysis is due on or before September 30th.
Accreditation Review Report				X	Upon completion or change in status
Adult and Child Core Quality Measures			X		On or before September 1st
Provider Reporting					
Provider Network Adequacy		X	X	X	• Full network – Annually by October 31st • All Network changes by specialty – Quarterly, forty-five (45) days after end of the quarter • PCP changes –fourteen (14) days after the change • Hospital changes –immediately • Material changes of other providers affecting service delivery- fourteen (14) days after the change
Provider Credentialing		X			Within forty-five (45) calendar days of end of quarter (by the 15th day of the second month following the end of the reporting period)
Provider Satisfaction Survey		X			Within forty-five (45) calendar days of end of quarter (by the 15th day of the second month following the end of the reporting period)
Suspension and Adverse Enrollment Action Report (formerly the CAF Suspension and PDC reports)	X				By the fifteenth (15th) day of the following month
Financial Reporting					
Offices of the Insurance Commissioner Reports – Quarterly and Annually		X	X		Concurrent with DOI submission
Third Party Liability Cases Not Pursued	X				The fifteenth (15th) day of each month (to include all events from the prior month)
Provider-Preventable Conditions			X		July 15th

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
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 fifteen (15) business days of test completion
Information Security Plan				X	Within ten (10) business days of Department written request
Health Information Systems Strategy				X	
System Quality Assurance Plan				X	Within ten (10) business days of Department written request

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
MCO Annual Report			X		On or before April 1st
Organization Chart			X		On or before October 1st
Marketing Plan			X		On or before October 1st
Care Coordination Program Description			X		On or before October 1st
Subcontractor Agreement Report			X		On or before July 1st
Subcontractor Monitoring Plan				X	Within ten (10) business days of Department written request
Subcontractor Conflict Mitigation Plan				X	Within ten (10) business days of Department written request
Data Accuracy and Completeness Plan			X		On or before October 1st
Activities Summary, Analyses and Results of Provider/Beneficiary Utilization to Detect FWA			X		On or before August 15th
HB 4217 Report			X		On March 1st of each year
Alternative Payment Model Report			X		August 15th
FWA Reporting	X				By the fifteenth (15th) day of the following month
Disclosure of Ownership Reporting			X	X	• Annually, on or before July 1st; • Upon request, within thirty-five (35) calendar days; or • Upon change in ownership, within thirty-five (35) calendar days
FWA Internal Compliance Plan			X		On or before October 1st
Parity in Mental Health and Substance Use Disorder (SUD) Benefits Compliance Plan			X		On or before June 30th
Claims Aging Report	X				By the fifteenth (15th) day of the following month
Mental Health Parity Report		X			Forty-five (45) days after end of each quarter
Parity in Mental Health and Substance Use Disorder (SUD) Benefits Compliance Plan			X		On or before June 30th

Reporting Requirement	Timeframe				
	Monthly	Quarterly	Annually	Other	Due Date
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; • Provider training/development reports; • Provider concerns and complaints • 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 1: DATA CERTIFICATION FORM

STATE OF WEST VIRGINIA

DATA CERTIFICATION FOR _____ REPORT SUBMISSION

The MCO must submit this certification form concurrently with all reporting. Please list all reports included in this certification.

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), the data contained in the _____
<name of report> _____
Report submission by _____
<MCO> _____
is accurate, complete, and truthful, and that it has no known or suspected material limitations or imperfections unless described in detail in a statement provided with this submission.

I further certify that I have authority* to sign this certification on behalf of _____
<MCO> _____

Certified by*: _____
Name

_____
Title

_____
Date of Submission

^ 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)).

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)).

APPENDIX F: SERVICE LEVEL AGREEMENTS (SLA) AND LIQUIDATED DAMAGES MATRIX

All areas of responsibility and all requirements in the Contract will be subject to performance evaluation by the Department. Any and all responsibilities or requirements not fulfilled may have remedies, and the Department will assess either actual or liquidated damages. This Appendix outlines performance standards that carry liquidated damage values.

#	Program Non-Performance	Measurement Period	Liquidated Damages
1	Failure to submit required reports, information requests, documentation, ad hoc reports, data certification forms, overpayment remittances, or any other item required within the timeframes provided by this Contract or by the Department. The MCO may have a one (1) business day grace period following the due date of the data, report, remittance, or form. Article II, Section 4.13, unless otherwise specified in this Appendix.	Ongoing	$250 per business day per each item that is overdue until the satisfactory submission of the required report, documentation, ad hoc report, data certification form, or data required to meet any State or federal reporting requirements After three (3) instances of non-performance during the Contract period, the amount is increased to $1,250 per business day per each item that is overdue.
2	Failure to comply with encounter data submission requirements including the failure to address or resolve problems with encounter records in a timely manner as required by Article III, Section 5.10.	Monthly	$1,000 per single encounter file per reporting period.
3	Failure to meet a ninety-six percent (96%) encounter acceptance rate as required by Article III, Section 6.10 and 6.10.5.3.	Monthly	$100 per each rejected encounter below the ninety-five percent (96%) acceptance rate threshold.
4	Failure to 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 an enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. Article III, Section 4.8.	Quarterly	$1,000 for each percentage point below ninety-eight percent (98%) if the MCO fails to meet the standard.
5	Failure to notify affected enrollees of program or service site changes, at least thirty (30) calendar days before the intended effective date of the change. Article III, Section 4.4.	Ongoing	$250 per each incident per affected enrollee.
6	Failure to report timely to the Department significant network changes as described in Article III, Section 3.1, Network Changes.	Ongoing	$500 per incident of non-compliance.

#	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.

#	Program Non-Performance	Measurement Period	Liquidated Damages
15	Failure to adhere to the prohibitions and requirements related to program integrity activities and the recovery of overpayments as outlined in Article III, 9.	Ongoing	$5,000 per occurrence, plus forfeiture of all related recovered overpayments.
16	In addition to the liquidated damages described in this table, the state agency reserves the right to assess a general liquidated damage with any notice of deficiency.	Ongoing	$500 per occurrence of any deficiency.
17	Failure by the MCO to ensure at least eighty- three percent (83%) of provider calls are answered live within thirty (30) seconds during operating hours.	Monthly	$5,000 per month for non-compliance.
16	Failure by the MCO to ensure the provider call abandonment rate does not exceed five percent (5%).	Monthly	$5,000 per month for non-compliance.
18	Failure by the MCO to ensure a mental health screening has been completed for any child entering the child welfare system that is not actively receiving mental health services.	Monthly	$5,000 per incident.
19	Failure by the MCO to ensure timely member discharge from the residential setting.	Monthly.	$25,000 per member per month.
20	Failure to timely report violations in the access, use and disclosure of PHI or timely report a security incident. Violations must be reported within sixty (60) calendar days and without reasonable delay after discovery.	Ongoing	$500 per enrollee per occurrence, not to exceed $10,000,000.

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.

Calculating MLRs

The MCO must calculate its program MLR utilizing the following formula:

The MLR is 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)). The MLR must be rounded to three decimal places. For example, if an MLR is 0.7988, it must be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it must be rounded to 0.825 or 82.5 percent.

The MCO may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any rebates and in accordance with 42 CFR §438.8(h).

If the 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.

Allocation of Expenses

The MCO must follow a generally accepted accounting methodology anticipated to yield the most accurate results and must ensure the following:

1. Any expense may be reported under only one type of expense, unless a portion of the expense fits under the criteria for one type of expense and the remainder fits the criteria for another type of expense. In this case, the expense must be pro-rated between the types of expenses.
2. Expenses that benefit multiple contracts or multiple populations within this contract must be reported on a pro rata basis.
3. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
4. Any expenses that relate solely to the operation of a reporting entity (e.g., personnel costs for processing claims) must be borne only by the reporting entity and may not be attributed to other entities.
5. Liquidated damages, provider overpayment remittance to the State and interest assessments, if any, are unallowable costs and are neither medical expenses nor premium payments.

Incurred Medical Expenses (Numerator)

The numerator of an MLR must include total incurred medical expenses defined.

Per 42 CFR §438.8(e)(2) incurred claim means the following:

- Direct claims that the MCO paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of additional and Value-Added services per 42 CFR §438.3(e) provided to MCO enrollees;
- Unpaid claims liabilities for the MLR reporting period, including claims reported that are in the process of being adjusted or claims incurred but not reported;

- 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

actual service. Detailed documentation must include support for how the MCO and/or its vendors identified, assessed, and allocated the cost, the regulations and guidance used to make their determinations, and how outcomes are measured. The expense reported must be the actual cost incurred by the servicing entity for providing HCQI or HIT services to MHP enrollees. For staffing, assessments must be made at each staff position to identify the HCQI or HIT qualifying allowable and non-allowable qualifying activities. Time studies must be used to determine how to allocate staffing and related direct overhead expense. Other direct expenses should be allocated using a methodology that will yield the most accurate results. Direct overhead expense includes, but is not limited to, compensation to staff, software specifically used to perform HCQI activities (these software expenses are allowable under Health Information Technology) and member engagement and education. Indirect expense is not allowed as reportable HCQI or HIT expense. Indirect expense includes, but is not limited to marketing, overhead, lobbying, general IT and infrastructure, office space, utilities, training, executive salaries, and software that is not specifically used to perform HCQI activities.

Activities conducted by the MCO to improve quality must meet the following requirements:

(1) MCO activity related to any EQR-related activity as described in 42 CFR §438.358(b) and (c); or

(2) The activity must be designed to:

a. Improve health quality.

b. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

c. Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

d. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(3) The activity must be primarily designed to:

a. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among MCO specified populations. Examples include the direct interaction of the MCO (including those services delegated by Contract for which the MCO retains ultimate responsibility under this Contract), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

i. Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in Section 3502 of the ACA.

ii. Identifying and addressing ethnic, cultural, or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine.

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:

iv. Wellness assessments;

v. Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

vi. Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

vii. Public health education campaigns that are performed in conjunction with State or local health departments;

viii. Actual gifts or incentives that are not already reflected in claims;

ix. Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

x. Coaching or education programs and health promotion activities designed to change enrollee behavior and conditions (for example, smoking or obesity); and

xi. Health information technology to support these activities.

e. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology. Expenditures and activities that must not be included in quality improving activities are:

vi. Those that are designed primarily to control or contain costs;

vii. Those which otherwise meet the definitions for quality improvement activities, but which were paid for with other funding separate from capitation revenue;

viii. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

ix. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.

x. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

xi. All retrospective and concurrent utilization review;

xii. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

xiii. Provider credentialing;

xiv. Marketing expenses;

xv. That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

xvi. Any function or activity not expressly included in this Appendix, unless otherwise approved by and within the discretion of the Department, upon adequate showing by the MCO that the activity's costs support the definitions and purposes in this part or otherwise support monitoring, measuring, or reporting health care quality improvement.

Expenditures Related to Health Information Technology (HIT) and Meaningful Use Requirements (Numerator)

The MCO may include activities that improve health care quality such Health Information Technology (HIT) as expenses that are required to accomplish the activities allowed in this

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);

- State-developed one-time payments, for specific life events of enrollees (e.g., kick payments);
- Withhold arrangement payments to the MCO approved under 42 CFR §438.6(b)(3);
- Unpaid cost-sharing amounts that the MCO could have collected from the members under the contract, except those amounts the MCO can show it made a reasonable, but unsuccessful, effort to collect;
- All changes to unearned premium reserves;
- Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 CFR §438.5 or 42 CFR §438.6.

Pursuant to 42 CFR §438.8(f)(1) and (3), the WV MCO premium tax described in Article III, Section 8.6 will be excluded from the denominator of the MCO's MLR.

Federal, State, and local taxes and licensing and regulatory fees must include at least the following:

- Statutory assessments to defray the operating expenses of any State or Federal department;
- Examination fees in lieu of premium taxes as specified by State law;
- Federal taxes and assessments allocated to MCOs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes;
- State and local taxes and assessments including:
    - Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
    - Guaranty fund assessments.
    - Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
    - State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
    - State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes;
- Payments made by an MCO that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR §158.162(c), limited to the highest of either:
    - Three percent (3%) of earned premium; or
    - The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's earned premium in the State.

Pursuant to 42 CFR §438.8(f)(1) and (3), the WV MCO premium tax described in Article III, Section 8.6 will be excluded from the denominator of the MCO's MLR.

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.

APPENDIX H: ALTERNATIVE PAYMENT MODEL (APM) REPORTING TEMPLATE

NAME OF MCO
CONTACT INFORMATION
INITIATIVE(S) SELECTED (Options include, but are not limited to: primary care incentives; payment for performance; shared savings arrangements; risk sharing arrangements; episodes of care/ bundled payments; and capitation payments with performance and quality requirements)
DESCRIPTION OF INITIATIVE(S) (Please include provider partners, percentage of provider contracts, size and scope of initiative, effect on quality and cost to date) *APMs must encompass 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.
RATIONALE FOR INITIATIVE(S)
Which value based health care goals are supported by this initiative? Check Box(es) ☐ Improve Quality of Care ☐ Lower Costs ☐ Improve Population Health Further Explanation:

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)

BARRIERS (Please describe any significant barriers faced and strategies developed to overcome these barriers)
PLANS FOR NEXT CONTRACT YEAR

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.

Waiver Requests - Providers wishing to employ any individual with a conviction listed above in Section 1 should direct the following documents to the Bureau for Social Services, 350 Capitol Street, Room 692, Charleston, WV 25301:

4. Criminal Record Statement Form completed by the prospective employee prior to fingerprints being sent to the State Police. This allows the prospective employee to explain the surrounding circumstances for any criminal activity that may appear on the CIB check;
5. CIB results from the West Virginia State Police; and
6. A statement of why the waiver should be granted that is completed by the prospective employee. If the request is being submitted by an agency, the director of the agency must submit a statement along with the waiver request indicating support. The request will not be considered if the agency does not submit a statement of support.

APPENDIX J: 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, 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 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 specialists, other specialists, and hospitals. The requirements for each specialty group are outlined below.

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/ 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
	Pulmonology	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
	Physical Medicine and Rehabilitation Specialist	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
	Speech 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
Other Specialist			
	Chiropractic	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
	Dialysis	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
	Durable Medical Equipment (DME)	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
	Endocrinology	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
	Hematology	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
	Home Health Services	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
	Nephrology	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
	Neurosurgery	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
	Orthotics and Prosthetics	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
	Plastic 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
	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
	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

Provider Category	Provider Type	Adult Standard	Pediatric Standard
	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.

Dental Network Access Standards

The MCO must contract with a sufficient number of active dental providers accepting patients and meet the following standards for all 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
General Dentist	Dentist	Two (2) providers within twenty-five (25) **miles** or thirty (30) **minutes** travel time	Two (2) providers within twenty-five (25) **miles** or thirty (30) **minutes** travel time
Dental Specialist	Oral Surgeon	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
	Orthodontist	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

Behavioral Health Network Access Standards

The MCO must contract with a sufficient number of active behavioral health and SUD providers accepting patients and meet the following standards for all adult and pediatric populations. For review purposes, behavioral health providers are grouped as behavioral health providers, behavioral health facilities, SUD providers, or SUD facilities. The MCO is required to contract with all Drug Free Moms and Babies sites. The requirements for each specialty group are outlined below.

Provider Category	Provider Type	Adult Standard	Pediatric Standard
BH Provider	Psychologist	Two (2) providers within forty-five (45) **miles** or sixty (60) **minutes** travel time	Two (2) providers within forty-five (45) **miles** or sixty (60) **minutes** travel time
	Psychiatrist	Two (2) providers within forty-five (45) **miles** or sixty (60) **minutes** travel time	Two (2) providers within forty-five (45) **miles** or sixty (60) **minutes** travel time
	Licensed Professional Counselor (LPC)	Two (2) providers within forty-five (45) **miles** or sixty (60) **minutes** travel time	Two (2) providers within forty-five (45) **miles** or sixty (60) **minutes** travel time
	Licensed Independent Clinical Social Worker (LICSW)	Two (2) providers within forty-five (45) **miles** or sixty (60) **minutes** travel time	Two (2) providers within forty-five (45) **miles** or sixty (60) **minutes** travel time

Provider Category	Provider Type	Adult Standard	Pediatric Standard
BH Facility	Adult Inpatient Psychiatric Unit	**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	N/A
BH Facility	Behavioral Health Clinics	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
BH Facility	Psychiatric Residential Treatment Facility (PRTF)	N/A	One **(1)** provider within forty-five **(45) miles** or sixty **(60) minutes** travel time
SUD Provider	Outpatient 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
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

Essential Community Providers (ECPs)

Essential Community Providers (ECPs) are types of providers and settings that serve predominantly low-income and medically underserved populations such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The MCO must contract with as many FQHCs and RHCs as necessary to permit beneficiary access to participating FQHCs and RHCs without having to travel a significantly greater distance past a non-participating FQHC or RHC. An FQHC or RHC that is not accepting new patients will not satisfy these requirements. The requirements for FQHCs and RHCs are outlined below.

Provider Type	Adult Standard	Pediatric Standard
FQHC or RHC	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

Network Adequacy for Additional Providers Types

The Department may identify additional providers when it promotes the objectives of the Medicaid program as determined by CMS. The MCO must contract with a sufficient number of these providers who are accepting patients and must meet the following standards for all adult and pediatric populations. The requirements for additional providers are outlined below.

Provider Type	Adult Standard	Pediatric Standard
Additional Provider Type to promote the objectives of the Medicaid program as determined by CMS	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

Network Submission and Network Adequacy Evaluation

In accordance with the preceding standards, the MCO must submit to the Department the following provider network information as described below.

Provider Network Submission

Submission of Geographic Data Maps

The MCO must provide individual geographic maps for all medical, dental, and behavioral health provider, ECP, and other provider types and subtypes defined in the preceding standards. Each map must either clearly demonstrate which providers are accepting new patients or only include providers that are accepting new patients.

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.

Provider Network Evaluation

The Department will evaluate the provider-to-enrollee PCP and OB/GYN network adequacy ratios for the MCO in each county. In evaluating, the Department will compare the number of the MCO's unique providers located within the county to the number of the MCO's enrollees within the county.

To review compliance with time and travel distance standards, the Department will review geographic data maps and supporting tables to verify appropriate enrollee access to all provider types. BMS defines adequate access as ninety percent (90%) of enrollees in each county have access to every provider type within the specified time and travel distance standards.

If any specialty services cannot be provided by a contracted provider, the MCO must demonstrate how it will ensure Medicaid enrollees access to this specialty (e.g., allowing out-of-network referrals when appropriate). The Department will evaluate the number and location of contracted specialists and provisions to ensure access where contracted specialists are not available in determining the overall adequacy of the specialist network in a given county.

The Department or its contractor will assess the network against the Department's network requirements and provide an assessment of network adequacy to the MCO in a timely manner.

Exception Requests

The Department will consider requests for exceptions to the provider access standards under limited circumstances (e.g. if no appropriate provider types are located within the mileage standards) and may, in its sole discretion, grant exceptions to these standards. Each exception request from the MCO to the Department must be in writing and include detailed information with supporting documentation regarding how they will mitigate the provider network deficit and meet the needs of the enrollees. Exceptions to network requirements will be considered based on the information provided, current patterns of care, and locations where the travel time and distance standards differ significantly from providers in the community.

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 Greenhow

WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES

STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Alex J.Mayer
Cabinet Secretary

Cynthia Beane, MSW, LCSW
Commissioner

DATE: August 4, 2025

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 4
Dept 0511

The West Virginia Bureau for Medical Services (BMS) respectfully requests the approval of the above-referenced CMA change order four (4). 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 two (2) of three (3) one (1)- year renewals. The service period will be 07/01/2025-06/30/2026. 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 304-352-3924 or althea.m.greenhowe@wv.gov. Thank you for your time and consideration in this matter.

Backdate approved

STATE OF WEST VIRGINIA
DEPARTMENT OF ADMINISTRATION
OFFICE OF TECHNOLOGY

Eric L. Householder
Cabinet Secretary

State Capitol
Charleston, West Virginia 25305

Heather D. Abbott
Chief Information Officer

TO: **Curtis Burress, Information Systems Consultant**
Office of Shared Administration, Information Systems

FROM: **Heather D. Abbott, Chief Information Officer**
Office of Technology Heather D. Abbott

SUBJECT: **INFORMATION TECHNOLOGY PROCUREMENT**
WVOT Number 2025-2720

DATE: **July 30, 2025**

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.

A review has been conducted of your request for approval for Change Order 4, Contract Renewal for CMA BMS23*03, the Office of Technology has determined:

X 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.

An official website of the United States government Here's how you know

Records Retention Policy Impacts Old SAM Registration Data
Show Details
May 21, 2025

See All Alerts

Subaward Reporting is live on SAM.gov **Show Details**
Mar 8, 2025

SAM.GOV®

Home Search Data Bank Data Services Help

Search All Words e.g. 1606N020Q02

Filter By

Keyword Search

For more information on how to use our keyword search, visit our help guide

Simple Search **Search Editor**

- ◯ Any Words ⓘ
- ◯ All Words ⓘ
- ◯ Exact Phrase ⓘ

e.g. 1606N020Q02

"coventry health care of west virginia inc" ×

Federal Organizations

Enter Code or Name ▾ ⋯

Status

- [x] Active
- [ ] Inactive

Reset

All Domains | Contracting | Federal Assistance | Entity Information | Federal Hierarchy | Wage De

No matches found

Your search did not return any results.

To view Entity Registrations, Subcontract Reports, Subaward Reports you must sign in.

Sign In

Would you like to include inactive records in your search results?

Yes **Go Back**

Feedback

You are viewing this page over a secure connection. Click here for more information.

West Virginia Secretary of State — Online Data Services

Business and Licensing

Online Data Services Help

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	5242 - Finance and Insurance - Insurance Carriers and Related Activities - Agencies, Brokerages and Other Insurance Related Activities (claims adjusting, third-party administration)	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
Director	TODD R. WHITE 500 VIRGINIA STREET E. SUITE 400 CHARLESTON, WV, 25301
Director	***SEE ATTACHED LIST***
President	TODD R. WHITE 500 VIRGINIA STREET E. SUITE 400 CHARLESTON, WV, 25301
Secretary	THORNE WASHBURN CLARK 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

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 4(.T NO PAR VALUE.

Date	Amendment
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.

Annual Reports

Filed For
2025
2024
2023
2022
2021
2020
2019
2018
2017x
2017
2016
2015
2014
2013
2013
2012
2011
2010
2009
2008
2007

2005
2004
2003
2002
2001
2000
1999
Date filed

For more information, please contact the Secretary of State's Office at 304-558-8000.

Tuesday, August 5, 2025 — 10:39 AM

© 2025 State of West Virginia

COMPLIANCE VERIFICATION CHECKLIST
FOR REQUISITION SUBMISSION

Purchasing Division Use: Buyer: Crystal Hustead Date: 8/5/25 Solicitation No. CMA BMS23*03	Agency: BMS
	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: Stephanie Hustead